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THE COMMONWEALTH OF MASSACHUSETTS

MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE

CODE OF MASSACHUSETTS REGULATIONS

TITLE 106 CMR CHAPTERS 501-507

THE MEDICAL ASSISTANCE POLICY MANUAL

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501.000: Overview of General Policies

This chapter introduces the Medical Assistance (MA) Program and the Department of Public Welfare, hereinafter, Department, which administers the Program in the Commonwealth of Massachusetts.

The policies described in this chapter are the basis of the administration and operation of the Program and support the policies in subsequent chapters. This chapter addresses the authority of the Department, the framework for the administration of the Program, the rights and responsibilities of applicants and recipients, and Program definitions.

501.100: Authority of the Department of Public Welfare

The Massachusetts Department of Public Welfare is established by Massachusetts General Laws, Chapter 18. Under this law, as amended, the Department administers various programs established or authorized by the Legislature or Special Laws of the Commonwealth, by Executive Order of the Governor of the Commonwealth, and by agreements with the United States Department of Health and Human Services (DHHS).

The regulations of the Department are promulgated in accordance with General Laws, Chapter 30A, as amended, and in accordance with other applicable General Laws of the Commonwealth.

501.200: The Medical Assistance (MA) Program

The Medical Assistance (MA) Program is a program in which the federal and state governments share the cost of payments to medical service providers on behalf of eligible individuals and families. At the federal level, the Program is authorized by Title XIX of the Social Security Act, and is administered by the Health Care Finance Administration of the Department of Health and Human Services (DHHS) (Medicaid Program). Massachusetts General Laws, Chapter 118E, as amended, provides for the Medical Assistance Program to be administered in the Commonwealth by the Massachusetts Department of Public Welfare.

501.210: Administration of the Medical Assistance Program

Medical Assistance Program policy is formulated by the Central Office of the Department of Public which also provides general administrative direction for the Program.

Eligibility for Medical Assistance is determined at local Area and Branch Offices and Long-Term-Care Units. District Offices of the Social Security Administration determine eligibility for SSI cases.

501.220: Medical Assistance Eligibility Regulations

(A) The Medical Assistance Policy Manual is the sole source of eligibility regulations of the Department and has the authority of law. Relevant regulations must be cited as support for case actions affecting the eligibility of applicants and recipients.

(B) A copy of the manual shall be made available for public inspection at each of the Department's local offices.

501.230: Special Eligibility Situations and Limitations

(A) (1) Medical Assistance coverage is provided automatically to recipients of Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), and the Refugee Resettlement Program (RRP).

(2) Persons who have been denied assistance under one of these programs may make separate application for Medical Assistance only.

(B) (1) An applicant or recipient of Emergency Aid to the Elderly, Disabled, and Children (EAEDC) who is between the ages of 18 and 65 may apply for Medical Assistance if he or she chooses, in accordance with 106 CMR 319.730. Such application is not a condition of EAEDC eligibility.

(2) An applicant or recipient who is under the age of 18 or aged 65 or over must apply for Medical Assistance as a condition of eligibility for EAEDC in accordance with 106 CMR 319.730.

(3) Applicants for or recipients of EAEDC between the ages of 18 and 65 may be required to apply for SSI-D as a condition for receiving EAEDC. Such application is not a requirement for receiving Medical Assistance. If the applicant for or recipient of EAEDC wishes to apply for MA/DA, he or she must be allowed to do so. The Department will process such applications and determine disability pursuant to 106 CMR 504.700 in the same manner and in accordance with the same time standards as all other MA/DA applications. The applicant is eligible for MA if he or she meets the basic, categorical, and financial requirements for MA/DA.

(C) An individual who would be eligible for SSI if he or she met the SSI requirement to accept treatment for drug addiction or alcoholism may receive MA only.

(D) Persons who are recipients of assistance in another state are not eligible for Medical Assistance. When applying for Medical Assistance in the Commonwealth, a former recipient of assistance in another state shall verify that such assistance has been terminated.

(E) Individuals who would be eligible for SSI because of blindness, except for their level of income or resources, shall apply for Medical Assistance with the Massachusetts Commission for the Blind.

501.300: Rights of Applicants and Recipients

The policies of the Medical Assistance Program shall be administered in accordance with federal and state law. Applicants and recipients shall be informed in writing of their rights and responsibilities with respect to the Medical Assistance Program.

(A) Right to Nondiscrimination and Equal Treatment

All activities conducted by the Department must be carried out in accordance with Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), the Age Discrimination Act of 1975, as amended (42 U.S.C. §6101 et seq.), and the Massachusetts Constitution. The Commonwealth of Massachusetts, Department of Public Welfare, does not discriminate on the basis of race, color, sex, national origin, handicap or age in admission or access to, or treatment or employment in, its programs or activities. An Affirmative Action Officer has been designated to help coordinate the Department's effort to comply with the U.S. Department of Health and Human Services regulations (45 C.F.R. Parts 80, 84 and 91) implementing these federal laws. For further information about the regulations and the Department's grievance procedures for resolution of discrimination complaints, contact the Affirmative Action Officer, Department of Public Welfare, 180 Tremont Street, Boston, MA 02111.

(B) Right to Confidentiality

The confidentiality of case information is protected in accordance with applicable federal and state statutes and regulations. The use and disclosure of information concerning applicants, recipients, and legally liable third parties is restricted to purposes directly connected with the administration of the Medical Assistance Program.

(C) Right to Timely Provision of Benefits

Eligible recipients have the right to the timely provision of benefits.

(D) Right to Information

Individuals who inquire about Medical Assistance, either orally or through a written request, shall be provided information about benefits, eligibility, and rights and responsibilities associated with the Medical Assistance Program.

Non-refugee alien applicants for MA shall be advised that the receipt of assistance may result in an adverse decision by the Immigration and Naturalization Service (INS), should the alien apply for "permanently admitted" status.

(E) Right to Be Assisted by Others

The applicant or recipient has the right to be assisted, accompanied and/or represented by any individual of his choice in any contact with the Department.

The individual providing assistance may act on behalf of an applicant or recipient provided he meets the definition of a representative (see Section 501.500(PP).

(F) Right to Apply

Any person, individually, or through a representative, has the right, and must be afforded the opportunity without delay, to apply for Medical Assistance.

(G) Right to Inspection of the Case Record

The applicant or recipient has the right to inspect information in the case record in accordance with applicable statutes and privacy regulations, and to challenge the accuracy of case information.

(H) Right to Appeal

The applicant or recipient has the right to request, in writing, and be granted a prompt, fair hearing on any Departmental action or on any claim for service that is not acted upon with reasonable promptness except that the Department need not grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.

501.400: Responsibilities of Applicants and Recipients

The applicant, recipient, or his representative shall cooperate with the Department and shall provide information necessary to establish or maintain eligibility. Failure to cooperate in fulfilling his responsibilities to the Department may result in the denial or termination of assistance. Responsibilities include the following:

(A) Reporting Changes in Circumstances

The applicant or recipient shall report promptly and accurately to the Department any changes in circumstances that may affect eligibility.

(B) Providing Verification

The applicant or recipient has the primary responsibility for providing all obtainable verifications required by the Department. (See 106 CMR 502.410.)

(C) Cooperating with Quality Control

If the recipient's case is selected for review, he or she shall cooperate with representatives of the Department's Quality Control Division.

501.500: Definition of Terms

The terms listed below have the following meanings for the purposes of the MA Program.

(A) Affidavit

An affidavit is a written or printed statement of fact sworn to or affirmed before a person having legal authority to administer such an oath.

(B) Appeal

An appeal is a written request, by an aggrieved applicant or recipient, for a fair hearing.

(C) Asset Limitation

The asset limitation is the maximum dollar value of assets owned by, or available to, a filing unit, which if exceeded, results in ineligibility.

(D) Assets

Assets are holdings of value that include, but are not necessarily limited to, cash, bank deposits, securities, real estate, cash value of life insurance, automobiles, boats and trailers, and any other real or personal property.

(E) Assistance Unit

The assistance unit consists of those persons who are applying for and are receiving Medical Assistance.

(F) Caretaker Relative

A caretaker relative is an adult who has specified relationship to and resides with a dependent child.

(G) Case Maintenance

Case maintenance consists of all activities necessary to maintain current and accurate case information and to meet all administrative requirements of the Department.

(H) Case Record

The case record is the permanent written collection of documents and information required to determine eligibility and to provide benefits to applicants and recipients.

(I) Community Case

A community case is one in which the individual or family resides in the community and receives Medical Assistance for occasional and acute medical services.

(J) Competent Medical Authority

In certain situations, verification by an appropriate competent medical authority is required.

A competent medical authority is a physician or psychiatrist licensed by any state or a psychologist licensed by the Commonwealth of Massachusetts or, for the limited purpose of diagnosing pregnancy and pregnancy-related incapacity, a nurse practitioner or a nurse midwife who meets the educational and certification requirements mandated by state law and/or regulations.

(K) Dependent Child

A dependent child is a child under the age of 18 who meets certain specified requirements for relationship, living arrangements, and deprivation.

(L) Deprivation

Deprivation is an eligibility requirement for a dependent child applying for MA/AFDC and shall be established in accordance with 106 CMR 504.300 et seq.

(M) Disability Determination Unit

A Disability Determination Unit consists of physicians and disability evaluators who make determinations of permanent and total disability using criteria established by the Social Security Administration under Title XVI.

(N) Eligibility Process

The eligibility process consists of the activities conducted for the purpose of determining, redetermining, and maintaining the eligibility of a Medical Assistance applicant or recipient.

(O) Filing Unit

The filing unit consists of all individuals whose assets and income must be considered in the determination of the financial eligibility of the assistance unit. An individual may be in more than one filing unit but in only one MA assistance unit.

(P) Gross Income

Gross income is the sum total of money, goods, or services, earned or unearned, such as salaries, wages, rents, tips, bonuses, annuities, or income-in-kind, received from any source without regard to income deductions.

(Q) Health Maintenance Organization (HMO)

A provider approved by the Commissioner of the Massachusetts Division of Insurance to furnish comprehensive health services, or that otherwise meets the definition of an HMO under the state Medical Assistance plan.

(R) Income Deductions

Income deductions are specified deductions that may be made from the gross income of an applicant or recipient.

(S) Income-in-Kind

Income-in-kind is income in any form other than cash provided to the applicant or recipient. It may consist of free services, free rent, free utilities, clothing, or food, but it is not necessarily limited to these. It may be earned or unearned.

(T) Institution (Medical)

An institution is a public or private facility providing acute, chronic, or long-term care, unless otherwise defined within these regulations.

(U) Long-Term-Care (Health or Medical) Facility

A long-term-care facility is a licensed nursing home, intermediate care facility for the mentally retarded, public or private institution for mental diseases, or freestanding hospice.

(V) Managed Care

Primary care and referral services.

(W) Net MA Income

Net MA income is gross income less applicable income deductions.

(X) Patient Paid Amount

The patient paid amount is that portion of long-term-care costs that must be borne by the recipient.

(Y) Permanent and Total Disability

An individual shall be considered to be permanently and totally disabled if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months (or, in the case of a child under the age of 18, if he or she suffers from any medically determinable physical or mental impairment of comparable severity or is unable to engage in age-appropriate activities).

For purposes of this definition, an individual aged 18 or over shall be determined to be under a disability only if his or her physical or mental impairments are of such severity that he or she is not only unable to do his or her previous work but cannot, considering age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy, regardless of whether such work exists in the immediate area in which he or she lives, or whether a specific job vacancy exists or whether he or she would be hired if he or she applied for work. For purposes of the preceding sentence (with respect to any individual), "work that exists in the national economy" means work that exists in significant numbers either in the region where such individual lives or in several regions of the country.

For purposes of this definition, a child under 18 shall be determined to be under a disability only if his or her physical or mental impairments are of such severity that he or she is unable to engage in age-appropriate activities. This determination shall be made by the Department or its designee in accordance with applicable regulations, rules, or definitions applied to the same determination by the Social Security Administration pursuant to Title XVI of the Social Security Act.

(Z) Personal Needs Allowance

The personal needs allowance (PNA) is the designated portion of monthly income that an individual in long-term care is allowed to retain for personal expenses. In some instances, the Department pays all or a portion of the PNA to the recipient. The PNA shall not be used for any item included in the daily rate at the long-term-care facility.

(AA) Personal Needs Allowance (PNA) Account

The personal needs allowance (PNA) account is an account administered by a long-term-care facility on behalf of a recipient. Regulations regarding the administration of PNA accounts are contained in 106 CMR 456.801 et seq.

(BB) Primary Care

The provision of coordinated, comprehensive medical services on both a first contact and continuous basis to an enrolled recipient by a Primary Care Clinician. It incorporates several tasks: medical diagnosis and treatment, personal support, communication of information about illness prevention, and health maintenance.

(CC) Primary Care Clinician (PCC)

A provider of managed care to recipients in the MassHealth/Managed Care program. The PCC must meet the requirements of 106 CMR 450.118(B). The PCC must be a participating provider and must sign a provider agreement with the Department to participate as a PCC.

(DD) Prospective Eligibility Period

The prospective eligibility period is a specified period of six months of eligibility for community cases and one month of eligibility for long-term-care cases, except those identified in 106 CMR 506.620(B).

(EE) Quality Control

Quality control is a system of continuing review to measure the accuracy of eligibility decisions.

(FF) Redetermination

A redetermination is a review of a recipient's circumstances to establish whether he or she remains eligible for benefits.

(GG) Representative

A representative is:

(1) a person with written authorization by an applicant or recipient to act on his or her behalf;

(2) a person appointed by the court to act on behalf of an applicant or recipient;

(3) a person acting responsibly on behalf of a deceased applicant or recipient; or

(4) a spouse or member of the applicant's or recipient's immediate family acting responsibly on his or her behalf.

The representative must be sufficiently aware of the applicant's or recipient's circumstances to assume legal responsibility for the accuracy of statements made during the eligibility process.

If the applicant or recipient is unable to provide the written authorization, a determination of eligibility shall still be made within Departmental timeliness standards. However, the written authorization shall be submitted at the earliest possible opportunity.

(HH) Reverse Mortgage

A reverse mortgage is a loan on the equity value of a house paid in installments by a bank to the homeowner who is aged 60 or over.

(II) Spenddown Case

A spenddown case is one in which the net MA income of the filing unit exceeds the MA Income Standard at 106 CMR 506.410. The filing unit must incur medical expenses equal to the excess income for the appropriate period of time before eligibility can be established.

(JJ) Supplemental Security Income (SSI) Program

The Supplemental Security Income (SSI) Program provides financial assistance to needy persons who are aged 65 or older, blind, or disabled. This program is established under Title XVI of the Social Security Act and is administered by the Social Security Administration (SSA). Such persons automatically receive Medicaid that is provided and administered by the Department of Public Welfare.

(KK) Third-Party Liability

Third-party liability is the legal obligation of any person, company, or agency to pay all or part of an individual's medical expenses. Except where a specific agreement pursuant to 42 CFR 433.139 exists, the Department is in all instances the payer of last resort.

(LL) Third-Party Resource

A third-party resource is any source -- person, company, or agency -- having responsibility for a third-party liability.

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502.000: Overview of the Eligibility Process

(A) The eligibility process consists of the activities conducted for the purposes of determining, redetermining, and maintaining the eligibility of a Medical Assistance applicant or recipient.

(B) As part of the eligibility process, the applicant or recipient must meet the requirements of this chapter as well as the basic, categorical, and financial eligibility requirements of later chapters.

502.100: Application Process

The application process consists of all activities conducted for the purpose of determining the eligibility of Medical Assistance applicants. These activities are initiated with the filing of an application and concluded with a final disposition of the application.

502.110: Right to Apply

(A) Every person, individually, or through a representative, has the right, and must be afforded the opportunity without delay, to apply for Medical Assistance.

(B) A mentally capable individual who files an application on behalf of himself or another assumes legal responsibility for the accuracy of all statements made during the application process.

502.120: Special Application Requirements

Special application requirements exist when application is made for:

(A) Retroactive Eligibility

(1) An application for retroactive Medical Assistance may be made by an applicant or recipient of Medical Assistance Only or of any federal cash category of assistance. Retroactive applications shall be made on a form prescribed by the Department.

(2) Eligibility may be retroactive to the first day of the third month prior to the month of initial application if covered medical services were received during such period and the applicant or recipient would have been eligible for Medical Assistance at the time the services were provided. Only income and assets that were actually available during the retroactive period shall be considered in determining eligibility.

(3) The processing of requests for retroactive eligibility shall conform to Department timeliness standards.

(B) A Deceased Person

An application may be filed by a representative on behalf of a deceased individual. Eligibility is determined retroactive from the date of death but may not be earlier than the first day of the third month prior to the month of application.

When an individual dies after filing an application but before an eligibility determination has been made, eligibility shall be determined for the period between the date of application and the date of death, and retroactively upon proper application.

(C) The Blind

An application on behalf of a legally blind individual should be filed through the Massachusetts Commission for the Blind.

502.125: Responsibility for Eligibility Determination

Individuals and families shall make application at the local office serving the community in which they currently reside.

If the applicant subsequently moves to an area covered by another office before a determination of eligibility is made, the original office shall retain responsibility for completing the application process. The new office shall cooperate with the original office and shall assist the applicant when necessary. If the applicant is determined eligible, the case shall be established and transferred by the original office within ten calendar days of the eligibility determination to the new office.

502.130: Application Activities

Application activities include the following:

(A) Completion of Application Form

Each application form shall be accompanied by a notice providing the applicant with instructions for completion of the form; a list of common forms of documentation that may be submitted to satisfy verification requirements; and a statement advising the applicant of the availability of worker assistance.

The applicant is responsible for the filing and completion of the form. The Department shall determine if the application is complete.

(B) Date of Application

The date of application is the date that a signed and dated application is received at the appropriate local office. If an applicant for Medical Assistance has been denied assistance for AFDC or SSI within the thirty days prior to the application for MA, the date of application for MA shall be the date on which he applied for AFDC or SSI.

(C) Face to Face Interview

The Department has the right to require face to face interviews when deemed necessary.

(D) Request for Specific Verifications

If all required verifications are not received with the completed application form, the worker shall inform the applicant by means of a written notice on a form prescribed by the Department of all outstanding eligibility factors that must be verified. The notice shall advise the applicant of the date by which the verifications must be received, the consequence of the failure to provide the verification, and the procedures for obtaining an extension of time. The notice shall further advise the applicant of the alternative verifications that may be submitted to satisfy the requirement and shall contain a statement offering assistance in obtaining acceptable documentation of the required verifications.

(E) Request for Social Security Number

The Department shall advise the applicant of (1) the regulation under which the Department is requesting the social security number (SSN); and (2) the uses the Department will make of each SSN requested.

The worker shall request that the applicant (1) furnish or apply for an SSN for each individual for whom Medical Assistance is requested in accordance with 106 CMR 503.250; and (2) furnish an SSN for each legally liable third party.

(F) Request for Health Coverage Information

The Medical Assistance Program pays for health care services only when no other source of payment for the services is available. An applicant must provide information regarding any existing health care coverage that is or may be available to any member of the filing unit and must apply for any such coverage that is available to him or her without additional cost.

If all conditions of eligibility are met, the Medical Assistance Program will provide payment for covered services not met by any other third party coverage.

(G) Information from Government Sources and Banks

The applicant or recipient must be informed that the Department will regularly request information from other sources for purposes of verifying eligiblity. These include banks and other financial institutions, the Division of Employment Security, the Registry of Motor Vehicles, the Bureau of Vital Statisitcs, Veterans' Services, the Department of Revenue, the Bureau of Special Investigations, the Internal Revenue Service, the Social Security Administration and other programs administered by the Department of Public Welfare.

The Department need not obtain the prior approval of the applicant or recipient to acquire and use information from banks of government sources to verify eligibility.

502.140: Eligibility Determination

Every application process shall be concluded by a determination of eligibility as supported by the facts in the case record. The applicant shall be notified in writing of the approval or denial of his application. If eligibility is approved, the notice to the applicant shall include the effective date of eligibility and the names of eligible recipients.

If the worker, despite efforts required by subsection 502.410(b)(5) to assist in obtaining verification, is unable to complete the application process solely because of the lack of verification required to make a determination of eligibility, assistance shall be denied. If the applicant subsequently submits the required verifications within thirty calendar days of the date of the denial notice, the worker shall make a second determination of eligibility based on the original date of application. The determination shall be based on information submitted during the initial application process and during the thirty days subsequent to the denial notice. If the verifications demonstrate that the applicant was eligible for all or any part of this time period, the date of eligibility shall be established in accordance with Section 502.160.

If the applicant, or any other member of the filing unit for whom assistance is requested is determined ineligible, the applicant shall be notified in writing of the denial. The notice shall include the reason(s) for the denial, the specific regulation supporting the denial, and an explanation of the right to appeal. If eligibility is denied due to excess income, the applicant shall be informed of the amount of excess income and the requirements he must meet to establish eligibility. If the adverse action is the result of the lack of verifications required to make a determination of eligibility, the written notice shall contain a statement informing the applicant of the missing verification and that a second eligibility determination will be made, based on the date of application, if all required verifications are submitted within thirty calendar days of the date of the denial notice.

If the recipient appeals an adverse action in which the sole issue is the lack of verifications and if the recipient subsequently provides the required verifications during the appeal process, the Department shall take action in accordance with Section 343.350(B) of the Fair Hearing Regulations.

(A) Voluntary Withdrawal

The applicant or representative acting on behalf of the applicant may voluntarily withdraw his application. A representative may also withdraw an application for a deceased applicant. The request to withdraw an application shall be made in writing, shall be confirmed by a notice sent to the applicant, and shall be recorded in the case record.

(B) Inability to Locate

Eligibility shall be denied when the worker has attempted to contact the applicant by mail and the mail is returned as undeliverable with no forwarding address, and other reasonable attempts to locate the applicant have been unsuccessful.

502.150: Time Standards for Eligibility Determination

A determination of eligibility shall be made within Departmental timeliness standards. In unusual circumstances, (e.g., delay on the part of a third party or incapacity or illness of the applicant) the time for determining eligibility shall be extended.

A temporary Medicaid Eligibility Card may be issued in accordance with Section 502.330.

502.160: Date of Eligibility

The effective date of prospective eligibility is the earliest day, in the month of application, on which the applicant meets all eligibility requirements.

The effective date of retroactive eligibility shall be the earliest day, prior to the date of application, on which the applicant met all eligibility requirements, but shall be no earlier than the first day of the third calendar month preceding the month of application.

502.200: Redetermination Activities

A redetermination is a review of a recipient's circumstances to establish whether he remains eligible for benefits. A secondary purpose of the redetermination process is to detect fraud.

Redetermination activities include the following:

(A) The Completion of the Prescribed Redetermination Form

Each redetermination form shall be accompanied by a notice providing the recipient instructions for completion of the form; the date by which the form must be returned to the local office; a list of common documentation that may be submitted to satisfy verification requirements; and a statement advising the recipient of the availability of worker assistance. The recipient is responsible for the completion of the form.

The Department shall determine if the form is complete.

(B) Face to Face Interview

The Department may require face to face interviews as deemed necessary.

(C) Request for Specific Verifications

If all required verifications are not received with the completed redetermination form, the worker shall notify the recipient in writing of all outstanding verifications that are required at redetermination in accordance with Section 502.430. The notice shall advise the recipient of the date by which such verifications must be received; the consequence of a failure to provide such verifications; and procedures for obtaining an extension of time. The notice shall further advise the recipient of the alternative verifications that may be submitted to satisfy the requirement and shall contain a statement offering assistance in obtaining acceptable documentation of the required verification.

(D) Request for Social Security Number

The worker shall request that a social security number be furnished or applied for as specified in Section 502.130 (E) and 503.250.

(E) Request for Health Coverage Information

The Medical Assistance Program pays for medical services only when no other source of payment for the services is available. An applicant/recipient shall provide information on any existing health care coverage that is or may be available to any member of the filing unit.

If all conditions of eligibility are met, the Medical Assistance Program will provide payment at the rate prescribed by the Rate Setting Commission for Medicaid covered services that are not covered by any third party coverage.

502.210: Eligibility Redetermination

Every redetermination process shall be concluded by an eligibility decision that must be supported by the facts in the case record.

If the recipient's eligibility is to continue without interruption, written notice need not be sent.

If the worker is unable to complete the redetermination because the recipient has died, cannot be located or has not responded to the redetermination notice, assistance shall be terminated after proper notification.

The recipient must be notified in writing if eligibility is to be terminated. The notice shall include the reason(s) for the termination, the termination date, the specific regulations supporting termination and an explanation of the right to appeal. If eligibility is denied due to excess income, the applicant shall be informed of the amount of excess income and the requirements he must meet to establish eligibility.

If the worker, despite efforts required by subsection 502.410(B)(5) to assist in obtaining verifications, is unable to complete the redetermination process solely because of the lack of verifications required to make a determination of eligibility, assistance shall be terminated after proper notification including a statement of the missing verification(s). If the recipient subsequently submits the required verifications within thirty calendar days of the termination date, the worker shall make a second determination of eligibility based on the information submitted during the redetermination process as well as on information submitted within thirty calendar days of the termination date. If the recipient is determined to be eligible, assistance must be authorized retroactive to the date of termination provided the verifications demonstrate continuous eligibility, or retroactive to the date all eligibility factors are met, whichever is later.

If the recipient appeals an adverse action in which the sole issue is the lack of verifications and if the recipient subsequently provides the required verifications during the appeal process, the Department shall take action in accordance with Section 343.350(B) of the Fair Hearing Regulations.

(A) Voluntary Withdrawal

The recipient may request at any time that eligibility be terminated. If the request is made in writing, eligibility may be terminated without advance notice. If the request is oral, a termination notice shall be mailed at least ten calendar days in advance of the proposed termination.

(B) Inability to Locate

Eligibility shall be terminated when the worker is unable to complete the redetermination process because the recipient cannot be located. If mail is returned as undeliverable with no forwarding address and other reasonable attempts to locate the recipient have failed, eligibility shall be terminated.

(C) Failure to Submit Redetermination Form

If the recipient fails to submit the redetermination form within 30 days of the date mailed, eligibility shall be terminated.

502.220: Time Standards for Redetermination

A redetermination shall be completed at least every 6 months. Eligibility shall be redetermined more frequently if the Department obtains information indicating changes which affect eligibility or benefit level.

502.300: Case Maintenance

Case maintenance consists of any activities that are necessary to maintain current and accurate case information, to provide services to applicants and recipients, and to meet any administrative requirements of the agency. Case maintenance activities performed by the eligibility worker must be documented in the case record.

502.310: Maintaining the Case Record

The case record shall contain the application and redetermination forms, verifications, notifications, and other materials supporting a determination of eligibility or ineligibility, or any other case action.

502.320: Interim Changes

An interim change is any case action that takes place between determinations of eligibility. An interim change may result from information from any source including the Department.

If requested by the Department, the recipient shall provide additional verification. The worker shall notify the recipient of the specific verification needed, the date by which such verification must be received, and the consequence of failure to provide such verification. If the reported change indicates a need for comprehensive review of eligibility, the recipient may be required to submit a redetermination form and participate in the complete redetermination process.

(A) Responsibility for Reporting Changes in Circumstances

The applicant or recipient shall report to the Department within 10 calendar days all changes in circumstances that may affect his or her eligibility. The applicant or recipient shall be advised that fraudulent acts of false reporting in connection with the administration of the Medicaid Program are punishable by a fine of up to $10,000, up to one year imprisonment, or both.

(B) Time Standards for Interim Changes

A change of address must be implemented within 14 days of the date on which the change was reported or the date on which the Department learned of the change.

Other interim changes which are required must be made by the worker as soon as possible but no later than 45 days from the date on which they are requested.

502.330: Issuance of the MassHealth Card

A MassHealth Card(s) shall be issued for all eligible members of the grantee-relative's assistance unit(s). This card will be used by the medical services provider to verify the eligibility of each person listed on the card(s).

(A) The Temporary Medicaid Eligibility Card

A Temporary Medicaid Eligibility Card shall be issued to an applicant or recipient of Medical Assistance, including those eligible as categorically needy, when all the following conditions are met:

(1) the applicant or recipient has been determined eligible for Medicaid;

(2) the applicant or recipient requests a Temporary Medicaid Eligibility Card; or the worker receives information that the applicant or recipient needs immediate medical attention; and

(3) the MassHealth or Temporary Card has been lost, stolen, damaged, or has not yet been received.

(B) Time Standards for Issuance of Medicaid Eligibility Card

A Temporary Medicaid Eligibility Card shall be issued no later than the next working day following the date of request.

(C) Worker Responsibilities

The worker shall assist the applicant or recipient if he or she needs a referral to a Medical Assistance provider.

502.340: Issuance of PNA Replacement Checks

When a PNA check is reported stolen, lost, or not received, the worker shall determine the address to which the check was mailed and whether the check has been returned to the Department. If the check can be located, it shall be mailed to the recipient.

If the recipient has reason to believe that the check was stolen, the recipient or representative shall report the suspected theft to the police immediately.

The recipient may request a replacement check. The date of request shall be the date the recipient completes the prescribed form. The recipient shall be advised to return the original check if it is subsequently located or received.

(A) Authorization of a Replacement Check

The worker shall approve a request for a replacement check when all of the following conditions have been met:

(1) the original check is reported as lost, stolen, or not received;

(2) the original check cannot be located;

(3) at least 5 days have elapsed since the date the check was scheduled to be received, or at least 5 days have elapsed since the date the check was lost or reported stolen; and

(4) no more than 30 days have elapsed since the issuance of the original check. The office director or his designee shall be authorized to approve the replacement of a check if more than 30 days have elapsed since the issuance of the original check.

502.350: Time Standards for Issuance of Replacement Checks

The Department shall issue a replacement check within 26 days of the date the recipient signs the prescribed form.

If the original check is subsequently located and found to have been cashed, the recipient must also sign a notorized statement that the endorsement is not his. If the recipient admits to signing the original check or refuses to sign the notorized statement, the worker shall refer the case to the Bureau of Special Investigations.

502.400: Verifications

Verification is the validation of oral or written statements by means of documentation, third party contacts and affidavits by the applicant/recipient in accordance with Section 502.440. Verification must be provided during the eligibility or redetermination processes or at the time of changes affecting eligibility (See Section 502.430 Frequency of Verification). All documentation, as well as information obtained through third party contacts, shall be made part of the case record.

502.410: Responsibility for Verifications

(A) Responsibilities of Applicants and Recipients

To establish eligibility for MA, the applicant or recipient must meet basic, categorical and financial eligibility factors. The applicant or recipient must submit the verifications required by MA policy to demonstrate that he meets these eligibility factors.

The applicant, recipient, or his representative is responsible for the following:

(1) obtaining the required verification(s);

(2) contacting the worker if there is a delay or difficulty in obtaining the verification(s);

(3) cooperating in providing the worker with information needed to obtain the verification(s) when worker assistance is needed; and

(4) signing collateral consent forms, if necessary.

(B) Responsibilities of Workers

The worker is responsible for the following:

(1) identifying the eligibility factors that must be verified;

(2) identifying and providing written notice of the specific documents or the alternative documents, if applicable, that must be submitted to satisfy the eligibility factors;

(3) advising the applicant or recipient of the consequence of failure to provide verification(s);

(4) explaining the reason verification(s) are needed when requested and offering suggestions of where and how to obtain the verifications and;

(5) assisting in obtaining required verification(s) when the worker is aware that the applicant or recipient is unable to obtain the documentation for reasons beyond his control.

If the required documentation is not submitted and the worker is unable to obtain such verification or to determine if the MA eligibility factors have been met, assistance for the affected household member(s) must be denied or terminated.

502.420: Department's Right to Corroborate Statements

The applicant or recipient shall be advised and shall acknowledge in writing his understanding that all statements supporting the application for benefits are subject to corroboration, including contacts with collateral sources.

502.430: Frequency of Verification

Some information, because it is not subject to change, need only be verified once unless at a later date questions are raised about the current validity of the verification or unless the Department has reason to believe that a change has or may have occurred for which reverification is required. Such information includes but is not limited to the following: age; citizenship; alienage; application for potential benefits; death; paternity; pregnancy; principal earner status and work history; relationship; windfall/lump sum payments; and transfer of assets.

Information that is subject to frequent change must be reverified at redetermination, at times of reported change, or whenever the Department receives information that a change has, or may have occurred that affects continued eligibility. Such factors include but are not limited to bank deposits; personal needs allowance (PNA) accounts; cash on hand; the continued nature of a parent's absence; court-ordered child-support payments; medical expenses; health insurance coverage; incapacity; income; IRA's, Keogh's and pension plans; securities; unemployment or underemployment; and work-related expenses, i.e., dependent care.

Other factors are subject only to occasional change and therefore need only be reverified at the time of a reported change or whenever the Department has reason to believe that a change has or may have occurred for which verification is required. Such information includes, but is not limited to, the cash surrender value of life insurance; the fair market and equity value of real estate and vehicles; living arrangement; the reason for a parent's continued absence; temporary absence; residence; joint ownership of assets; and inaccessibility of assets.

Chapters 503, 504 and 505 contain information regarding specific eligibility factors (including those not mentioned in this section); the acceptable verification of those eligibility factors; and the frequency with which they must be verified.

The provisions of this section shall not apply whenever verification of an eligibility factor is required because the originally submitted documentation is missing or has been destroyed.

502.440: Methods of Verification

The acceptable sources of verification are detailed in the sections of these regulations where the eligibility requirement is stated. The method of verification differs depending upon the nature of the information.

If one method of verification is preferred to another, the preferred method is stated.

Method of verification include original documents, collateral contacts, and self-declarations.

(A) Original Documents

When the verification is an original document, a photocopy of the document must be made, if possible.

If the circumstances prevent the photocopying of a document and a copy is not available, the worker must record in the case record the date and source of the document, a summary of its contents and the date the summary was made. The applicant or recipient must be permitted to keep the original document.

(B) Collateral Contact

Collateral contact is verbal or written confirmation of a household's circumstances by a third party, and it may be used to verify certain types of information. The worker must obtain written consent from the applicant or recipient for each contact, except as specified in subsection 502.130(F). If the applicant or recipient refuses to allow the Department to verify information by contacting a third party, assistance must be denied or terminated unless the applicant/recipient provides alternative verification.

Statements from third parties may be accepted in person, through the mail, and over the phone.

The worker must evaluate the acceptability of the statement as verification of the particular information.

The worker must record the date on which the statement was made, the relevant information, the identification and position of the person making the statement, and a means of contacting the person in the future should it become necessary to support the applicant's or recipient's right of rebuttal at a hearing, if requested.

(C) Self-Declarations

A self-declaration is a written statement of fact that may be given by the applicant/recipient or by a third party who is familiar with the circumstances of the applicant/recipient.

A self-declaration may be accepted as verification of the following eligibility factors when the applicant/recipient has taken all necessary steps to obtain the documentary evidence required by Chapters 503, 504, and 505 and the original document is not available: the continued nature of and reason for a parent's absence, cash on hand, inaccessibility of joint bank accounts and securities, unemployment of the prinicipal earner, age, relationship, Canadian-born Indian status, paternity, health insurance coverage, temporary absence and good cause for refusing a bona fide offer or employment or training for employment.

The self-declaration must be filed in the case record.

502.450: Time Standards for Verifying Continued Eligibility

The recipient is responsible for providing verification of those eligibility factors that have not previously been verified as well as those that are subject to variation in accordance with Section 502.430. The recipient is responsible for cooperating with the worker in obtaining verification(s) of continued eligibility, or, for providing an acceptable reason for the unavailability of the verification(s) within ten calendar days of the worker's request.

The following are acceptable reasons for unavailability:

(A) the verification is dependent on a third party and the recipient has taken all necessary steps on his/her part to obtain it;

(B) illness or incapacity of the recipient or other family member has delayed provision of the required verifications(s);

(C) the recipient was not adequately informed of his responsibility to provide the required verification(s);

(D) the recipient was not informed of the specific documents, including alternative verification(s), required to verify the eligibility factor; or

(E) other circumstances beyond the control of the recipient.

If one of the above situations applies, the recipient will be informed of alternative verification methods, including self declaration, in accordance with Section 502.440 and allowed an additional ten calendar days to meet his verification responsibility. The worker shall also offer assistance in obtaining any requested documents and/or shall use collateral contact as a means of verification in accordance with subsection 502.440(C).

If the benefits of any member of the assistance unit are terminated due to the lack of verification(s) needed to make a determination of eligibility, the recipient must be sent a written notice of adverse action. (See Section 502.500: Notifications.) The written notice must contain a statement informing the recipient that a second eligibility determination will be made if the absent verifications and any verifications required by changes in circumstances that have occurred in the interim are submitted in the thirty calendar days following the termination date. If the recipient is subsequently determined eligible, assistance is authorized retroactive to the date of termination provided the verification(s) demonstrate continuous eligibility or retroactive to the date all eligibility factors are met, whichever is later.

502.500: Notifications

The applicant or recipient shall be provided with written notice of any action to be taken by the Department concerning any member of the filing unit for whom assistance has been requested.

Notice shall include a summary of the action; the reasons for the action; the regulatory citations supporting the action; an explanation of the right to request a fair hearing; the method by which a hearing may be obtained; and the right of the applicant or recipient to represent himself or to be represented.

If an adverse action is the result of the lack of verifications needed to make a determination of eligibility, the written notice must also contain a statement informing the applicant or recipient that a second eligibility determination will be made based on the date of application if all required verifications are submitted within thirty calendar days of the date of termination or the date of the denial notice.

In cases of an action based on a change in law, the applicant or recipient shall be notified of the circumstances under which a hearing will be granted.

When an institution or a representative makes application on behalf of an individual, notification shall be sent both to the named applicant and to the institution or representative.

In the case of death, notification shall be sent to the executor, administrator or other legal representative of the deceased's estate.

502.600: Appeals

Information regarding the appeal process, the applicant's or recipient's right to request a fair hearing, and the time standards governing appeal procedures are found in 106 CMR 343.000 et. seq., Fair Hearing Rules.

502.700: Cooperation with Quality Control

The Division of Quality Control periodically conducts an independent review of all eligibility factors and payments in a sampling of cases.

When a case is selected for review, the recipient shall cooperate with the representative of the Quality Control Division. Cooperation shall include, but not be limited to, a personal interview, and the furnishing of requested information.

Refusal or failure of the recipient to cooperate shall result in the termination of assistance.

502.800: Fraud

Any person who obtains benefits by knowingly and deliberately making false statements, suppressing facts, withholding information, making misrepresentations, or failing to give information about a change in circumstances that would affect eligibility, commits fraud.

502.810: Referrals to Investigative Units

In all cases of suspected fraud, the eligibility worker shall make a referral to the Bureau of Special Investigations. Cases of suspected vendor fraud shall be referred to Provider Review and Sanctions.

502.820: Recovery

The Department has the right to recover overpayments and/or monies, or the value of benefits, that are wrongfully or fraudulently obtained.

The Department may also recover assistance correctly paid from the estate of a deceased recipient under 106 CMR 502.900.

No lien or encumbrance, however, shall be imposed on the property of any individual prior to his or her death because of Medical Assistance paid or to be paid, on his behalf except: (1) pursuant to a court judgement for benefits incorrectly paid on behalf of a recipient; or (2) as allowed under 106 CMR 502.910.

502.900: Estate Recoveries

A recovery of Medical Assistance correctly paid from the estate of a deceased recipient is made only for (1) assistance paid after the recipient was 65 years of age or older; or (2) assistance paid on or after 3/22/91 while the recipient was an inpatient in a nursing facility or other medical institution, regardless of the recipient's age.

No recovery may be made from the estate of any person who on the date of admission to the long-term-care institution had long-term-care insurance whose coverage met the requirements of 211 CMR 65.00.

Recovery can be pursued only after the death of a surviving spouse, if any, and only at a time when there is no surviving child who is blind, permanently and totally disabled, or under the age of 21.

502.910: Real Estate Liens

(A) Requirements

The Department will place a lien prior to the death of a recipient against any real estate in which the recipient has an ownership interest. This lien will be placed only if all of the following conditions are met:

(1) The individual is an inpatient receiving long term or chronic care in a nursing facility or other medical institution.

(2) None of the following relatives are residing in the property:

(a) a spouse;

(b) a child under age 21 or a blind or permanently and totally disabled child; or

(c) a sibling who has an equity interest in the property and has been living in the house for at least one year prior to the recipient's admission to the medical institution.

(3) The state determines that the individual cannot reasonably be expected to be discharged from the medical institution and to return home.

(4) The individual has received notice of the state's determination that the above conditions have been met and that a lien will be placed. The notice shall include the individual's right to a hearing.

(B) Dissolution

The Department is required to dissolve the lien if the individual is discharged from the medical institution and returns home.

(C) Verifications

The applicant or recipient must cooperate in providing verification as to whether the conditions under 106 CMR 502.910(A) exist and in providing any information necessary for the Department to place a lien.

(D) Recording Fee

The Department shall not be required to pay a recording fee for filing a notice of lien or encumbrance or a release or discharge of a lien or encumbrance under this section.

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503.000: Overview of Basic Eligibility Requirements

All Medical Assistance applicants and recipients shall meet the basic eligibility requirements.

The basic eligibility requirements are residence, citizenship or alienage, furnishing of or application for a social security number, utilization of potential benefits, and assignment for recovery.

503.100: Residence

(A) Requirements

As a condition of eligibility, an applicant or recipient must:

(1) live in the Commonwealth, with the intent to remain permanently or for an indefinite period, but is not required to maintain a permanent residence or fixed address; or

(2) live in the Commonwealth at the time of application, having entered the Commonwealth with a job commitment or to seek employment, whether or not currently employed (e.g., migrant and itinerant workers).

(B) Verifications

(1) The individual must verify that he or she lives in the Commonwealth. The preferred sources of verification are:

a. a deed or other evidence of ownership of the property used as the applicant's or recipient's home;

b. a lease or other rental agreement for the property used as the applicant's or recipient's home;

c. voter registration record;

d. utility company record or bill bearing the applicant's or recipient's name and address;

e. motor vehicle license or registration;

f. a receipt or cancelled check for rent or mortgage payment;

g. a signed statement from the landlord or owner of a residence, provided that the landlord or owner is not a relative of the applicant or recipient;

h. postal service record containing the applicant's or recipient's name and address;

i. church or religious institution record;

j. an employment record; or

k. SC-1 for long-term care cases.

(2) If the applicant or recipient is homeless and if documentary evidence is not available, residence is verified by one of the following:

° a collateral contact with a person who can verify that the applicant or recipient lives in the area covered by the office in which he or she applied;

° a written statement signed by the applicant or recipient or by a person known to the household stating that the applicant or recipient lives in the area covered by the office in which he or she applied; or

° a home visit.

(3) The mandatory verification of a job commitment or an intent to become employed shall be a written statement from an employer, a job registration card or a DES registration card.

503.110: Temporary Absence

(A) Requirements

Temporary absences from the Commonwealth, with subsequent returns, or intent to return when the purposes of the absence have been accomplished, do not interrupt continuity of residence as long as the individual maintains a residence or has the intent to reside in the Commonwealth during the absence.

Temporary absences may be for health, business, school, vacation or family commitments. Temporary absences may include absences outside the United States and its territories.

(B) Verifications

Absence in excess of 30 days shall create a presumption of intent to abandon Massachusetts residency. The presumption may be rebutted by evidence of:

(1) an identifiable residence in the Commonwealth or an intent to maintain residency as required by Section 503.100; and

(2) the temporary nature of the absence in excess of 30 days as documented by medical records, short-term business contracts, records of school attendance, etc.

503.120: Residence of Institutionalized Individuals

(A) Requirements

(1) An individual who has been placed in an institution in another state through arrangements made by a public agency of the Commonwealth shall be considered a resident of the Commonwealth. An individual who has been placed in an institution in the Commonwealth by a public agency of another state shall be considered a resident of that state.

(2) Where an institutional placement has been made by other than a public agency, residency is determined in the following manner:

a. Where the institutionalized individual is under the age of 21, or became incapable of indicating intent before age 21, the individual's state of residence is:

1. the state of residence of the parent(s) or legal guardian at the time of placement;

2. the current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state; or

3. the state of residence of the person or party who files an application, if the individual has been abandoned by his or her parent(s), does not have a legal guardian, and is institutionalized in that state.

In addition, where the institutionalized individual became incapable of indicating intent before age 21, the state of residence is that of the parent applying for Medicaid on the individual's behalf, if the parents reside in separate states.

b. Where the institutionalized individual became incapable of indicating intent at or after age 21, the state of residence is the state in which the individual is physically present, except where another state makes a placement.

c. For any other institutionalized individual, including an individual under 21 who is emancipated from his or her parents, the state of residence is the state where the individual is living with the intent to remain permanently or for an indefinite period.

(3) The residence of individuals in penal and mental disease institutions shall be treated in accordance with the provisions of 106 CMR 503.130 and 503.140.

(B) Verifications

(1) The mandatory verification that an institutional placement was made by a state agency shall be a signed statement or document from the institution or agency.

(2) The mandatory verification of the institutionalized individual's age shall be in accordance with 106 CMR 504.600.

(3) The mandatory verification of ability to indicate intent shall be documentation from a competent medical authority indicating the date at which the individual was medically determined to be incapable.

503.130: Persons in Penal Institutions

An applicant or recipient who is an inmate of a penal institution shall not be eligible for Medical Assistance. Inmate status is not interrupted or terminated by a transfer to a public or private medical or mental institution.

503.140: Persons Institutionalized for Mental Diseases

An individual under the age of 18 or aged 65 or older who is a patient in a public or private institution for mental diseases may be eligible for Medical Assistance.

An individual who attains the age of 18 while a patient in an institution for mental diseases may be eligible for Medical Assistance until he or she attains the age of 22, provided he or she meets the categorical requirements of the MA/DA Program, in accordance with 106 CMR 504 et. seq.

An individual between the ages of 18 and 65 who is a patient in a public or private institution for mental diseases is not eligible for Medical Assistance except as provided in the preceding paragraph. If this individual enters an acute hospital from such an institution, he or she may establish eligibility for Medical Assistance while on inpatient status if otherwise categorically and financially eligible.

503.200: Citizenship and Alienage

(A) Requirements

Every adult member of an assistance unit who is age 18 or over must sign a declaration under penalty of perjury certifying whether he or she is a citizen of the United States or an alien in satisfactory immigration status. This requirement does not apply to applicants seeking Medical Assistance for emergency services as described in 106 CMR 507.600. The grantee-relative or authorized representative must sign the declaration on behalf of each child under 18 in the assistance unit. If an applicant is under 18 and has neither a grantee-relative nor an authorized representative applying on his or her behalf, the appplicant shall sign the declaration for himself or herself and all other assistance unit members under age 18. If the applicant or recipient is physically or mentally incompetent, an authorized representative shall sign the declaration on his or her behalf. An individual's failure to comply with these requirements shall result in his or her ineligibility for Medical Assistance. However, the financial responsibility requirements of 106 CMR 505.400 et seq. continue to apply.

To be eligible for Medical Assistance, an applicant or recipient must be one of the following:

(1) A citizen of the United States: i.e., any individual born in the United States or its territories; born of a parent who is a U.S. citizen; or naturalized; or

(2) An individual who is not a citizen but who:

a. has been lawfully admitted for permanent residence;

b. is permanently residing in the United States under color of law; or

c. has been granted lawful temporary resident status or lawful permanent resident status under sections 245A, 210, or 210A of the Immigration and Nationality Act (INA), maintains a valid immigration status, and is:

1. aged, blind, or disabled as defined in section 1614(a)(1) of the Social Security Act;

2. a child under 18 years of age; or

3. a Cuban/Haitian entrant as defined in section 501(e)(1) and (2)(A) of Public Law 96-422.

An individual, not described in (2)c. above, is ineligible for Medical Assistance for five years from the date he or she is granted lawful temporary resident status or lawful permanent resident status, except as provided in 106 CMR 507.320 and 507.600.

Aliens lawfully admitted for a temporary purpose, such as students, visitors, and diplomats, are not eligible for assistance.

(B) Verification of Citizenship

The verification of citizenship is mandatory. Citizenship shall be verified by one of the following:

(1) birth certificate;

(2) baptismal record;

(3) United States passport;

(4) hospital birth record;

(5) voter registration;

(6) court records;

(7) naturalization certificates;

(8) U.S. Citizen Identity Card (INS Form I-179); or

(9) U.S. Citizen Resident's Card (INS Form I-197).

(C) Verification of Alien Status

The status of an alien must be verified.

(1) The status of a person lawfully admitted for temporary residence is verified by INS Form I-688, Temporary Resident card or INS Form I-688A.

(2) The status of a person lawfully admitted for permanent residence is verified by:

a. An "Alien Registration Receipt Card" commonly referred to as a "Green Card" (INS Form I-151 or INS Form I-551 (Blue printing superimposed over a white background));

b. A "Re-entry Permit" used for travel purposes by persons who have been issued the INS-I-151 or the INS-I-551;

c. An official document (including a receipt showing a request for replacement) from INS verifying that the alien has applied for a replacement I-151 or I-551 in the event of loss or theft; or

d. Any other official document from INS that indicates permanent residence status:

(3) Verification of the status of a person permanently residing under color of law can be made by producing an Arrival Departure Record (Form I-94) with one of the following notations:

a. "Refugee-Conditional Entry" (pursuant to Section 203(a)(7) of the Immigration and Nationality Act (INA));

b. "Refugee-Paroled" (pursuant to Section 207(c) of the INA, in effect after March 31, 1980);

c. "Paroled-For Indefinite Period" (pursuant to Section 212(d)(5) of the INA. A Form I-94 endorsed to show parole for a specified period is not acceptable with the sole exception of those individuals indicated in e., f., g., and (4) d. below);

d. "Political Asylum Granted" (pursuant to Section 208 of the INA);

e. "Cuban/Haitian Entrant" (status pending) or the initials "OOE" or the words "Outstanding Order of Exclusion";

f. "Citizen of Cuba" either entered United States or paroled after April 20, 1980; or

g. "Citizen of Haiti" granted "Voluntary Departure" status or paroled. (This person must have been in INS proceedings as of June 19, 1980).

(4) Additional verification(s) of the status of a person permanently residing under color of law includes but is not limited to the following:

a. Documentation from INS (including a receipt showing a request for replacement) verifying that the alien has applied for a replacement I-94 in the event of loss or theft;

b. Documentation from INS verifying a grant of indefinite voluntary departure or an indefinite stay of deportation;

c. Documentation of continuous residence since January 1, 1972, including but not limited to rent receipts, library cards, bank statements, insurance policies, church membership, or affidavit of a third person;

d. Documentation that there has been contact with INS and INS is not currently contemplating enforcement of the deportation proceedings against the persons listed below:

1. an alien whose nonimmigrant visa has expired;

2. an undocumented alien who has notified INS of his or her presence;

3. an alien who has a pending request with INS for indefinite voluntary departure, deferred action status, or stay of deportation;

4. a non-Cuban/Haitian entrant whose I-94 is endorsed to show parole for a specified period;

5. a Cuban/Haitian who entered the United States prior to 10/10/80;

6. an individual whose application for political asylum is currently pending with INS or an Immigration Judge.

503.210: American Indians Born in Canada

(A) Requirements

A person with at least 50 percent American Indian blood who was born in Canada and who has maintained residence in the United States since his or her entry is considered lawfully admitted as a nonimmigrant for purposes of Medicaid eligibility.

(B) Verifications

The verification of the lawful admittance of a Canadian-born Indian is mandatory and shall be one of the following:

(1) a "band card" issued by the band council of a Canadian Indian reserve;

(2) birth or baptism record indicating Canadian birth and providing evidence of Indian lineage;

(3) a provincial Union of Indians card (such as a Union of Nova Scotia Indians card); or

(4) an affidavit from a tribal official or other person with knowledge of the applicant's or recipient's family ancestry.

503.250: Social Security Number (SSN)

(A) Requirements

(1) As a condition of eligibility, each applicant or recipient must furnish a social security number for each person for whom assistance is requested or received.

(2) Each social security number must be verified by a computer match performed by the Department with the Social Security Administration (SSA).

a. SSA sources that verify the SSN include Bendex data, Numident, and State Data Exchange (SSI) information.

b. The Accretion Report verifies both the SSN and the fact that the number has been automatically accreted to the Masterfile.

(3) Any member of the assistance unit who is unable to furnish an SSN or for whom more than one SSN is furnished must provide verification from the SSA, in accordance with 106 CMR 503.250 (B)(3), stating that he or she has:

a. applied for a number;

b. applied to have an already existing number validated; or

c. made every effort to supply SSA with the information necessary to apply for an SSN or to apply to have an already existing number validated.

An applicant or recipient who does not provide such verification or furnish a social security number must be excluded from the assistance unit, except in the case of a newborn or certain refugees. The applicant or recipient may, however, be the grantee-relative for those children for whom a social security number has been furnished or an application initiated.

(4) The following are exceptions to the SSN requirement.

a. A newborn who is eligible for MA benefits in his or her first year because the mother was eligible for MA at the time of the birth. At the end of one year, the child's SSN must be furnished if his or her MA eligibility is to continue; and

b. A refugee who meets only the basic and financial requirements for MA, in accordance with 106 CMR 328.300(B).

Assistance may not be denied, delayed, or decreased pending the issuance or documentation of a social security number or application for a number if the applicant or recipient has complied or attempted to comply with the requirements for obtaining the number.

An SSN verified for another Department program shall be considered verified for the MA Program.

(B) Application and Validation of an Already Existing Number

(1) When an applicant or recipient cannot furnish the necessary social security number(s) because:

a. it has never been assigned;

b. the applicant or recipient no longer has any memory or record of the social security number; or

c. it is necessary to validate an already existing number when two or more numbers are furnished for a person,

the worker shall refer the applicant or recipient to the nearest Social Security office. The worker shall inform the applicant or recipient that the Social Security Administration may require verification of age, identity and citizenship or alien status.

(2) An applicant or recipient who cannot furnish an SSN for any of the above reasons must obtain verification from the SSA, as specified in 106 CMR 503.250(B)(3), stating that he or she has:

a. applied for an SSN;

b. applied to have an already existing number validated; or

c. made every effort to supply SSA with the information necessary to apply for an SSN or to apply to have an already existing number validated.

Upon delivery to the worker of such verification, the applicant or recipient shall be considered eligible to receive assistance providing that he or she meets all other eligibility requirements.

The worker shall provide the applicant or recipient upon request with any documents existing in the MA file that provide the verifications necessary to apply for an SSN or to apply to have an already existing number validated. The worker shall retain in the MA file a copy of any document(s) given to the applicant or recipient.

(3) Verification that an applicant or recipient has fulfilled the requirements specified in 106 CMR 503.250(B)(1) and (2) shall be provided at the following times:

a. at application, when the applicant or recipient cannot furnish the necessary SSN for any of the reasons listed in 106 CMR 503.250(B)(1) above;

b. when there is a match discrepancy, as specified in 106 CMR 503.250(C) below; or

c. where there is a question regarding the validity of the number and/or the identity of the applicant or recipient.

The signature of an SSA employee on the ENUM-2 form is the preferred verification that an applicant or recipient has applied for an SSN, has applied to have an already-existing number validated, or has made every effort to supply SSA with the information necessary to apply for an SSN or to apply to have an already-existing number validated. In the absence of the ENUM-2 form, one of the following shall be sufficient:

a. form 5028 from SSA;

b. form SSA 2853; or

c. any other communication, written or oral, from an SSA office, verifying that the applicant or recipient has applied for an SSN, has applied to have an already-existing number validated, or has made every effort to supply SSA with the information necessary to apply for an SSN, or to apply to have an already-existing number validated.

(C) Match Discrepancies

When an applicant or recipient furnishes a number that cannot be verified by computer match with the SSA in accordance with 106 CMR 503.250(A) above, the worker shall refer the applicant or recipient to the nearest social security office.

An applicant or recipient whose SSN produces a match discrepancy must obtain verification from the SSA, as specified in 106 CMR 503.250(B)(2) above, stating:

(1) that he or she has applied for an SSN;

(2) that he or she has applied to have an already-existing number validated; or

(3) that he or she has made every effort to supply SSA with the information necessary to apply for an SSN or to apply to have an already-existing number validated.

Upon delivery of such verification to the worker, the applicant or recipient shall be considered eligible to receive assistance, provided that he or she meets all other eligibility requirements.

The worker shall inform the applicant or recipient that the Social Security office may require verification of age, identity and citizenship or alien status. The worker shall provide the applicant or recipient upon request with any documents existing in the MA file that provide the verifications necessary to apply for an SSN or to apply to have an already existing number validated. The worker shall retain a copy of any document(s) given to the applicant or recipient.

An applicant or recipient whose social security number produces a match discrepancy shall only be referred to SSA once to obtain verification that he or she has applied for an SSN or has applied to have an already existing number validated. Should a second match discrepancy occur after the applicant or recipient has provided the SSA verifications necessary to rectify the original match discrepancy, it will be assumed that the SSN furnished is valid and has been verified for purposes of eligibility, unless the identity of the applicant or recipient and/or the validity of the SSN become questionable.

(D) Right to Know Uses of Social Security Numbers

The applicant or recipient has the right to know how the Department will use his or her social security number, the numbers of all members of the assistance unit, and the number of any legally liable third parties. At the time the applicant is given the application form, he or she will also be given written notice of the following:

(1) the purposes for which the numbers are sought;

(2) that the SSN(s) will be computer cross-checked with social security numbers appearing in other personal data files;

(3) what those files are, whether within the Department, in other governmental agencies or elsewhere; and

(4) that failure to meet Department requirements for furnishing the social security number of any member of the assistance unit shall result in denial or termination of that individual's benefits.

503.300: Utilization of Potential Benefits

(A) Requirements

An applicant or recipient shall take all necessary steps to obtain benefits for which he or she may be eligible, unless he or she can show good cause for not doing so. Benefits under this provision include, but are not limited to the following:

(1) Social Security benefits;

(2) Medicare, Part A;

(3) Railroad Retirement benefits;

(4) Federal Veterans' Administration benefits, including payment provided by the Veterans' Administration to purchase Aid and Attendance;

(5) Civil Service Annuities;

(6) Unemployment Compensation;

(7) Worker's Compensation;

(8) State Retirement pensions; and

(9) any other pension or benefits.

Medical Assistance shall be provided while claims for other benefits are pending provided that eligibility is re-determined at the time of receipt of any such benefits.

Applicants and recipients shall not be required to apply for AFDC, GR, SSI, or Mass. State Veteran's Service benefits as a condition for receiving Medical Assistance only.

(B) Verifications

The verification of application for any benefits for which an applicant or recipient may be eligible is mandatory and shall be an official document from the appropriate agency or a signed statement from an agency representative certifying that application has been made.

503.400: Assignment of Rights to Third Party Payments

As a condition of eligibility, each applicant or recipient must assign to the Department certain rights to medical support and/or other payments for medical care from a third party unless the applicant's or recipient's rights to such support or third party payments are not assignable under law.

503.410: Assignment of Rights to Medical Support

(A) Requirements

Each legally able applicant or recipient must assign to the Department:

(1) His or her own rights to any medical support (specified as support for the purpose of medical care by a court or administrative order), and third-party payments for medical services provided for under the Medical Assistance Program; and

(2) The right of any other eligible individual for whom he or she can legally make an assignment to medical support (specified as support for the purpose of medical care by a court or administrative order) and third-party payments for medical services provided for under the Medical Assistance Program.

Each applicant or recipient who assigns his or her rights to the Department pursuant to this section must cooperate with the Department in identifying liable third parties, and in obtaining medical support or payments and liable third-party resources, unless good cause for refusing to cooperate is determined to exist in accordance with the criteria of 106 CMR 303.730 through 303.735. The Department will not attempt to obtain medical support pursuant to an assignment by an applicant or recipient for whom good cause for refusing to cooperate has been determined, unless the Department also determines that such an attempt can proceed without risk of harm to the applicant or recipient or his or her children if the attempt does not involve their participation.

If the applicant or recipient refuses to comply with the requirements of this section, he or she is ineligible for Medical Assistance. He or she may be the grantee-relative for the dependent children who are eligible.

The assignment referred to herein shall not waive the applicant's or recipient's independent right to seek medical support or any other support in any court proceeding.

(B) Verifications

The applicant or recipient shall make an assignment by signing a form prescribed by the Department. The Department shall explain

to the individual that by his or her signature he or she is assigning his or her rights to medical support and/or third party payments for medical care as a condition of eligibility for Medical Assistance.

An applicant's signature shall be obtained at application. A recipient's signature may be obtained at any time, but no later than at the next redetermination of eligibility.

503.415: Assignment of Rights to Spousal Support

An institutionalized spouse whose community spouse refuses to cooperate or whose whereabouts is unknown shall not be ineligible due to (1) assets determined to be available for the cost of care in accordance with 106 CMR 505.180; or (2) his or her inability to provide information concerning the assets of the community spouse when one of the following requirements is met:

(A) the institutionalized spouse assigns to the Department any rights to support from the the community spouse; or

(B) the institutionalized spouse lacks the ability to assign rights to spousal support due to physical or mental impairment as verified by the written statement of a competent medical authority; or

(C) the Department determines that the denial of eligibility, due to the lack of information concerning the assets of the community spouse, would otherwise result in undue hardship.

503.420: Cooperation in Obtaining Medical Support, Including Establishing Paternity

(A) Requirement

Each applicant or recipient must cooperate with the Department in obtaining medical care support and payments for herself or himself and for any child(ren) for whom Medical Assistance is requested.

Cooperation shall include, if necessary, cooperation in establishing paternity, locating an absent parent(s), providing information about the absent parent(s), appearing as a witness at court hearings or other proceedings, and in any other activities necessary to obtain medical support.

Each applicant or recipient is required to cooperate unless the Department determines that the person has good cause for refusing to cooperate, or that the applicant or recipient is a pregnant woman who meets the requirements of 106 CMR 504.120(A)(1)b.2.

(B) Determination of Noncooperation and Good Cause

Noncooperation and good cause shall be determined in accordance with 106 CMR 303.730 through 303.735.

503.430: Assignments for Third Party Recoveries

An applicant or recipient who, due to any accident, injury, or illness, may be eligible to receive compensation from a third party, shall file a claim for such compensation.

The Department shall determine whether an applicant or recipient has good cause for refusing to cooperate, in accordance with 106 CMR 303.730 through 303.735, if filing a claim is believed to be against the best interests of the person. An applicant or recipient need not file for third party compensation if the Department determines that the person has good cause for refusing to cooperate.

Any applicant or recipient who files a claim for third party compensation shall make an assignment on the prescribed form conveying and transferring to the Department the right to recover an amount equal to the Medical Assistance benefits provided from either the recipient or the third party.

The applicant or recipient shall assist the worker by providing information pertinent to the third party claim and shall cooperate with the Department's Assignment Collection Unit.

An applicant's or recipient's failure to cooperate with the Department shall result in a denial or termination of Medical Assistance.

503.440: Veterans' Administration Aid and Attendance Benefits

An applicant or recipient who is a veteran in a long-term-care facility must cooperate in applying for Veterans' Administration Aid and Attendance benefits. Aid and Attendance benefits are considered countable income and are used in the post-eligibility determination of Patient Paid Amount.

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504.000: Overview of Categorical Requirements

Eligibility for the Medical Assistance Program is based on certain federally mandated financial and categorical requirements.

(A) Families with children who receive or are deemed to receive cash assistance, caretaker relatives, individuals under the age of 18, and pregnant women shall establish eligibility based on certain AFDC Program requirements and are referred to as AFDC-Related assistance units.

(B) Aged and disabled individuals shall establish eligibility based on certain SSI Program requirements and are referred to as SSI-Related assistance units.

504.100: AFDC-Related Programs

Individuals and families may receive Medical Assistance benefits or establish eligibility as AFDC-Related assistance units if they meet the requirements of one of the following programs:

(A) the AFDC Program (recipients) as described in 106 CMR 301.000 et seq;

(B) the Refugee Resettlement Program (recipients) as described in 106 CMR 328.000 et seq; and

(C) the MA-AFDC Program as described in 106 CMR 504.100 et seq.

504.110: AFDC Recipients: Automatic Eligibility

(A) AFDC and RRP

Current AFDC and RRP cash assistance recipients, as well as certain individuals described in 106 CMR 504.110(B) who are deemed to be in receipt of AFDC or RRP, are eligible for MA without filing a separate application. However, if retroactive assistance is requested, a separate application must be made on a form prescribed by the Department.

(B) Deemed MA Eligibility

(1) AFDC Monthly Grant Less Than $10

Families who are denied an AFDC payment solely because the monthly payment would be less than $10 are deemed to be receiving AFDC for the purpose of establishing eligibility for medical assistance.

(2) Children Receiving Adoption Assistance or Foster Care Maintenance

Any child placed in subsidized adoption or foster care under Title IV-E of the Social Security Act is deemed to be receiving AFDC and will be eligible for medical assistance provided by the

state where the child resides. In addition, children receiving state-subsidized adoption payments from a state that is a member of the Interstate Compact on Adoption and Medical Assistance (ICAMA) will be eligible for medical assistance provided by the state where the child resides if that state is also a member of ICAMA. Any child receiving state-subsidized adoption payments from a state that is not a member of ICAMA or any child receiving state-subsidized foster payments will only be eligible for medical assistance provided by his or her state of origin.

504.120: Extended MA Eligibility After AFDC Termination for Reasons Other Than Employment

(A) Dependent children under age 18, caretaker relatives as described in 106 CMR 504.170, and pregnant women whose AFDC assistance has been terminated shall continue to receive Medicaid until a determination of ineligibility is made by the Department.

(B) Members of an AFDC assistance unit whose AFDC assistance has been terminated as a result (wholly or partly) of the receipt of or increase in spousal or child-support payments shall be eligible for Medicaid for the four-calendar-month period beginning with the month in which the unit becomes ineligible for AFDC, provided that the unit received AFDC in any three or more of the six months immediately preceding the month of termination from AFDC.

504.130: Extended MA (TMA) Eligibility After AFDC Termination for Employment Reasons

(A) Initial Six-Month Extension of Medicaid After Termination of AFDC for Employment Reasons

(1) Eligibility Requirements

Members of an AFDC assistance unit who have become ineligible for AFDC shall remain eligible for Medicaid for the six-calendar-month period beginning with the month in which the family becomes ineligible for AFDC provided that the unit:

a. received AFDC in any three or more of the six months immediately preceding the month the unit became ineligible for AFDC;

b. continues to include a child who meets the age requirements in 106 CMR 303.120 and 303.130 of a dependent child receiving AFDC; and

c. became ineligible for AFDC because:

1. of an increase in hours of or income from employment of the caretaker relative (the caretaker relative is a person who has day-to-day responsibility for the care and control of the dependent child.); or

2. a member of the family loses either the $30 and one-third or the $30 earned income disregard.

(2) Notice Requirements

a. The Department must notify the AFDC assistance unit in the AFDC termination notice of its right to a six-month extension of Medicaid. The notice shall include a description of the reporting requirements during the initial six-month extension and the reasons for which eligibility may be terminated.

b. In the third month of the initial extension of Medicaid, the Department must notify the family:

1. that the family has the option of receiving an additional six-month extension;

2. that the family must meet the reporting requirements in 106 CMR 504.130(A)(3);

3. of alternative coverage options, waiting periods, and coverage limitations associated with such options; and

4. whether premiums are required for such additional extended medical coverage.

c. In the sixth month of the initial extension of Medicaid, the Department must notify a family who has fulfilled the reporting requirements of 106 CMR 504.130(A)(3):

1. that the family has the option of receiving an additional six-month extension of medical coverage;

2. that the family must comply with the reporting requirements of 106 CMR 504.130(B)(3);

3. of alternative coverage options, waiting periods, and coverage limitations associated with such options; and

4. whether premiums are required for such additional extended medical coverage and the amount of any premium required for each of the first three months of the additional extension period.

(3) Reporting Requirements

To be eligible to receive an additional six-month extension of medical coverage, a family must submit a completed, signed report to the Department not later than the 21st day of the fourth month of the initial extension. The report shall include the following information:

a. the family's gross monthly earnings and costs for child care that are necessary for the employment of the caretaker

relative in each of the first three months of the initial extended period of Medicaid eligibility. The gross monthly income must include the earned income of all family members living in the home who were members of the filing unit the month the family became ineligible for AFDC as well as financially responsible persons who returned to the home during the extended period of Medicaid eligibility;

b. verification of earned income for the third calendar month of the reporting period and, when requested by the Department, verification of earned income and child-care expenses for the three-month period;

c. changes in family composition; and

d. information regarding health insurance available to family members.

Failure to comply with these reporting requirements shall result in termination of Medicaid on the last day of the sixth calendar month unless the family is able to establish good cause for failure to report in accordance with 106 CMR 504.130(C)(1).

(4) Termination of Initial Extension

During the initial six-month extension, Medicaid must terminate at the end of the first month in which the assistance unit no longer includes a child who meets the age requirement of a dependent child receiving AFDC. Prior to termination, the Department must:

a. notify the family of the reason for the termination; and

b. determine their continued eligibility for Medicaid.

(B) Additional Six-Month Extension

(1) Eligibility Requirements

The Department shall offer to each family that has received the initial six-month extension of Medicaid under 106 CMR 504.130(A) the option of extending medical coverage for an additional six-month period provided that:

a. the family received assistance during the entire initial six-month period; and

b. the family complied with the reporting requirements described in 106 CMR 504.130(A)(3).

(2) Notice Requirements

During the third month of the additional six-month extension,

the Department must notify the family of the reporting requirements in 106 CMR 504.130(B)(3). The notice shall also include a statement of the amount of any premium required for each of the last three months of the additional extension period.

(3) Reporting Requirements

A family receiving assistance under the additional extension period must submit a completed, signed report to the Department not later than the 21st day of the first month and the 21st day of the fourth month of the additional extension period. The reports shall include the following information:

a. the family's gross monthly earnings and actual costs for child care that are necessary for the employment of the caretaker relative in each of the preceding three months. The gross monthly income must include the earned income of all family members living in the home who were members of the filing unit the month the family became ineligible for AFDC as well as financially responsible persons who returned to the home during the extended period of Medicaid eligibility or the additional six-month extension;

b. verification of earned income for the third calendar month of the reporting period and, when requested by the Department, verification of earned income and actual child-care expenses for the three-month period;

c. changes in family composition; and

d. information regarding health insurance available to family members.

Failure to comply with these reporting requirements shall result in termination of Medicaid on the last day of the calendar month following the month the report is due unless the family is able to establish good cause for failure to report in accordance with 106 CMR 504.130(C)(1).

(4) Termination of the Additional Six-Month Extension

Termination of the additional six-month extension of medical coverage shall become effective once the Department has notified the family of the reasons for the termination. The Department shall terminate the additional six-month extension of medical coverage:

a. at the end of the first month in which the family no longer includes a child who meets the age requirement of a dependent child receiving AFDC. Prior to termination the Department must determine the child's eligibility for Medicaid;

b. if the family does not pay a required premium for any month of the additional six-month extension by the 21st day of the following month. The extension shall terminate at the end of the following month, unless the family has established good cause in accordance with 106 CMR 504.130(C)(3) for failure to pay the premium on a timely basis; and

c. at the end of the second or fifth month of the additional six-month extension period if:

1. the family fails to report to the Department by the 21st day of the first or fourth month in accordance with the requirements of 106 CMR 504.130(B)(3), unless the family has established good cause in accordance with 106 CMR 504.130(C)(1);

2. the caretaker relative had no earnings in one or more of the previous three months, unless such loss of earnings was due to an involuntary loss of employment, illness, or other good cause established in accordance with 106 CMR 504.130(C)(2); or

3. the family's average gross monthly earnings, less the family's actual cost of child care necessary for the employment of the caretaker relative during the immediately preceding three-month period, exceed 185% of the federal-poverty level in 106 CMR 506.430 applicable to the family's size.

Prior to termination of medical benefits under 106 CMR 504.130(B)(4)b. and c. 1 and 2, the Department must determine eligibility for Medicaid for all individuals in the family currently in receipt of Medicaid.

(5) Scope of Coverage

A family that meets the eligibility requirements of 106 CMR 504.130(B)(1), and has other health insurance, is eligible to receive Medicaid during the additional six-month extension on a fee-for-service basis.

A family that meets the eligibility requirements of 106 CMR 504.130(B)(1) and has no other health insurance may choose to receive medical coverage during the additional six-month extension either through a Health Maintenance Organization (HMO), as defined in 106 CMR 501.500(Q), or through a Primary Care Clinician (PCC), as defined in 106 CMR 501.500(BB).

(6) Premium

The Department may charge a premium to a family during the additional six-month extension of medical coverage. Such premium may be charged only if the family's average gross monthly income minus the actual child- care costs necessary for the employment of the caretaker relative for the premium-base period described in 106 CMR 504.130(B)(7)a. exceeds the federal--poverty-level income standards in 106 CMR 506.430 for the family size.

The monthly premium in either of the premium-payment periods described in 106 CMR 504.130(B)(7)b. may not exceed three percent of the family's average gross monthly earnings minus actual child-care costs necessary for the employment of the caretaker relative during the corresponding premium-base period.

(7) Definitions

a. Premium-base period is a three-month period beginning with the first or fourth month of the initial six-month extension period.

b. Premium-payment period is a three-month period beginning with the first or fourth month of the additional six-month extension of medical coverage.

(C) Good Cause

(1) Good cause for failure to comply with quarterly reporting requirements may be established only if at least one of the following situations exists:

a. verification of earnings is unobtainable by fault of the employer;

b. the recipient is unable to complete the quarterly report by the designated due date because of a verified emergency (as determined by the local office director or the director's designee); or

c. a recipient is unable to complete or file a quarterly report because he or she is illiterate, temporarily incapacitated, or has language limitations.

(2) Good cause for terminating employment or failure to have earnings in one or more of the previous three months is established according to 106 CMR 307.180(A).

(3) Good cause for not paying a premium on a timely basis may be established if a recipient is temporarily unemployed for good cause as described in 106 CMR 307.180(A).

504.140: AFDC-Related: MA-AFDC - Pregnant Women

A pregnant woman may establish eligibility for Medical Assistance for herself and her unborn child by making a separate application for the MA-AFDC Program. The unborn child(ren) will be counted as if born and living with the mother.

(A) Eligibility Requirements

If a pregnant woman and her unborn child(ren) meet the basic requirements of the Medical Assistance program and their filing unit's income is equal to or less than 185% of the federal-poverty-level income standards in 106 CMR 506.430, they shall be eligible while she is pregnant and for the two calendar months following the end of the pregnancy. Any change in the filing unit's income that occurs during this time period will not affect eligibility. Only the pregnant woman and her unborn child(ren) are eligible to receive assistance under these provisions.

(B) Verification Requirements

Verification of pregnancy is mandatory and shall be a written statement from a competent medical authority certifying the pregnancy.

(C) Income in Excess of 185% of the Federal-Poverty Level

If the income of a filing unit that includes a pregnant woman is above the standard appropriate for its size, then the woman's financial eligibility is determined according to the standards in 106 CMR 506.410.

(D) Eligibility of Other Family Members

The pregnant woman's husband and dependent child(ren) in the home must also meet the basic and financial requirements, as well as other categorical requirements, to be included in the assistance unit.

504.150: AFDC-Related: MA-AFDC - Child Born to Recipient of AFDC, SSI, or Any Category of MA

Eligibility for Medical Assistance shall be extended to a child born to a woman who was eligible for and receiving Medical Assistance through AFDC, SSI, or any category of Medical Assistance on the date of the child's birth. The child shall automatically be eligible for MA for one year provided the child continues to live with the mother. The mother's continued eligibility for MA is not required for the child to remain eligible for MA. The date of birth and the relationship of the child must be verified.

504.160: AFDC-Related: MA-AFDC - Individuals Under Age 18

Individuals under age 18 may establish eligibility for Medical Assistance by making application for the MA-AFDC Program. Eligibility for MA-AFDC is not tied to the deprivation requirements of the AFDC Program; therefore, persons under 18 may be eligible for MA-AFDC no matter with whom they reside.

In the case of a child under age 18 residing with his or her parent(s), an MA-AFDC filing unit consists of the child and his or her parent(s), unless the child meets the criteria described in 106 CMR 504.160(A)(1).

In the case of a child under age 18 not residing with his or her parent(s), or of a child who meets the criteria in 106 CMR 504.160(A)(1), the MA-AFDC filing unit consists solely of the individual(s) seeking Medical Assistance.

The MA-AFDC application shall be filed by an adult member of the filing unit, if any. Where there is no adult in the filing unit and there is a person responsible for the care of the child, that person shall file the application for MA-AFDC. If there is no person responsible for the child, or if the child meets the criteria in 106 CMR 504.160(A)(1)b., the child may file the application.

(A) Residing with Parent(s)

(1) When an individual under the age of 18 resides with his or her parent(s), the income and assets of the parent(s) are considered and counted in determining the eligibility of the assistance unit unless the individual:

a. is disabled and meets the criteria described in 106 CMR 507.200;

b. is pregnant, or is the parent of a child, or reasonably believes that he or she has or has come in contact with any disease defined as dangerous to public health by the Department of Public Health; and whose parents do not know that he or she is seeking or receiving medical care or they have refused to pay for such care; or

c. is receiving hospice care benefits as described in 106 CMR 507.400.

(2) If the individual is a child under age one who does not meet the requirements of 106 CMR 504.150, the child's financial eligibility is determined by comparing the income of the filing unit to 185% of the federal-poverty-level income standards in 106 CMR 506.430. If the income of the filing unit is above the standard appropriate for its size, then the child's financial eligibility is determined according to the standards in 106 CMR 506.410.

If a child is receiving inpatient services on the date of his or her first birthday and remains eligible for Medical Assistance under this provision, the child remains eligible until the end of the stay for which the inpatient services are furnished.

(3) If the individual is a child who is one, two, three, four, or five years of age, the child's financial eligibility is determined by comparing the income of the filing unit to 133% of the federal-poverty-level income standards in 106 CMR 506.430. If the income of the filing unit is above the standard appropriate for its size, then the child's financial eligibility is determined according to the standards in 106 CMR 506.410.

If a child is receiving inpatient services on the date of his or her sixth birthday and remains eligible for Medical Assistance under this provision, the child remains eligible until the end of the stay for which the inpatient services are furnished.

No asset test shall be applied when determining the eligibility of a child described in 106 CMR 504.160(A)(2) or (3).

(4) If the individual is aged six or older and was born after 9/30/83, the child's financial eligibility is determined by comparing the assets of the filing unit to the standards in 106 CMR 505.110 and the income of the filing unit to the federal-poverty-level income standards in 106 CMR 506.430. If the income of the filing unit is above the standard appropriate for its size, then the child's financial eligibility is determined according to the standards in 106 CMR 506.410.

(5) The financial eligibility of all other children under age 18 who are not described in 106 CMR 504.160(A)(1)-(4, shall be determined by comparing the assets of the filing unit to the standards in 106 CMR 505.110 and the income of the filing unit to the standards in 106 CMR 506.410.

(B) Not Residing with Parent(s)

(1) When an individual under age 18 does not reside with his or her parent(s), the income and assets of the parent(s), when actually contributed, are considered and counted in determining the eligibility of the assistance unit. The child's financial eligibility shall be determined in accordance with the income and asset standards described in 106 CMR 504.160(A)(2)-(5).

(2) An individual under the age of 18 not residing with his or her parent(s) shall not be denied assistance due to lack of parental support. The individual shall be referred to the Department of Social Services for child protective services if there is reasonable cause to believe that the child is suffering from abuse or neglect.

(C) Verifications

The verification of age is mandatory. Age shall be verified by one of the following:

(1) birth certificate;

(2) court records (e.g., adoption, separate support, adjudication of paternity);

(3) hospital birth record; or

(4) Notification of Birth (NOB-1) signed by appropriate hospital official.

(5) If none of the above documents is available, two of the following may be accepted, provided they both contain date of birth:

a. family bible or genealogical records;

b. baptismal certificate;

c. United States census records;

d. social security (RSDI) benefit records;

e. Immigration and Naturalization records;

f. school records;

g. insurance policies;

h. employment records;

i. newspaper records and local histories;

j. Indian agency records;

k. child welfare service records;

l. voluntary social service records;

m. church records;

n. passport;

o. Head Start program records;

p. day care center records;

q. other governmental records; or

r. an affidavit of a knowledgeable third person, if the applicant or recipient has demonstrated that he or she has tried unsuccessfully to obtain appropriate documents.

504.170: AFDC-Related: Caretaker Relatives

(A) A caretaker relative may establish eligibility for Medical Assistance provided he or she:

(1) is related to a dependent child, in accordance with the provisions of 106 CMR 504.200; and

(2) lives with a dependent child and is responsible for his or her day-to-day care and control, in accordance with 106 CMR 504.210.

(B) A caretaker relative may be eligible for Medical Assistance regardless of whether the dependent child is also applying for Medical Assistance.

(C) A caretaker relative who does not live with a child who is considered dependent may be eligible for MA-AFDC if he or she is under age 18 or is pregnant.

A child is considered dependent if he or she is under age 18 and is deprived of the care or support of at least one natural or adoptive parent through death, continued absence, physical or mental incapacity, or the unemployment of the principal earner, as described in 106 CMR 504.300 et seq.

504.200: Relationship

(A) Requirements

In MA-AFDC cases the caretaker relative must be related to the dependent child in one of the following ways:

(1) a blood relative, including a mother, father, sister, brother, niece, nephew, aunt, uncle, or first cousin or any of these relatives of the preceding generation as denoted by prefixes of grand, great, or great-great (second and third cousins are not included under this definition; blood relatives include those of half-blood);

(2) a stepfather, stepmother, stepbrother, or stepsister;

(3) a parent by legal adoption or any of the adopting parent's blood relatives as defined above, natural children, or adopted children; or

(4) a spouse of any person named above, even if the marriage has been terminated by death or divorce.

(B) Verification

(1) Relationship is verified by:

a. birth or baptismal certificate showing the name(s) of the parent(s); or

b. for school-aged children, school records showing the address of the child and the name and relationship of the relative responsible for the child.

(2) If neither of the above is available, or for children for whom school records are not available, relationship is verified by one of the following:

a. family bible or genealogical records;

b. passport;

c. hospital birth record or Notification of Birth form (NOB-1) signed by appropriate hospital official;

d. United States census records;

e. social security (RSDI) benefit records;

f. Immigration and Naturalization records;

g. court records (e.g., adoption, separate support, adjudication of paternity); or

h. an affidavit of a third person, if the applicant or recipient has demonstrated that he or she has tried to obtain an appropriate document.

(3) Any of the following, provided they are dated at least six months prior to the date of application and provided they contain evidence of the relationship, are also acceptable verification:

a. insurance policies;

b. employment records;

c. newspaper records and local histories;

d. Indian agency records;

e. child welfare service records;

f. voluntary social service records;

g. church records;

h. Head Start program records;

i. day care center records; or

j. other governmental records.

(4) Marital relationship is verified by a license or certificate of marriage.

504.210: Living Arrangement

A dependent child must live with a relative responsible for his or her day-to-day care and control in a place of residence maintained as a home. The child is considered to be living with the relative so long as the relative has physical possession of the child, except for temporary absences as described in 106 CMR 504.210(A)(1), even if the child is under the jurisdiction of the court (for example, receiving probation services or protective supervision) or legal custody is held by an agency.

(A) Requirements

(1) The child and the relative are considered to be living together in the home even though either the child or the relative is temporarily absent from the home so long as the relative continues to excercise responsibility for the day-to-day care and control of the child. Absences may include attendance at educational institutions or specialized schools, hospitalization, employment, visits, and similar situations of a temporary nature. A child who spends time with a second parent as a result of a shared custody agreement is not excluded from eligibility under this requirement. Regardless of a shared custody arrangement, only one of the child's natural or adoptive parents may be the eligible caretaker relative for that child at any one time.

(2) The child is not considered to be living with the relative if the relative does not have physical possession of the child or if the child has been voluntarily placed under M.G.L. c. 119 s. 23(A) or is in the care or custody of a public or licensed private agency pursuant to any temporary or final court order under M.G.L. c. 119.

(3) The child will be considered to be living with the relative through the end of the month in which the child is removed from or leaves the home of the relative. If the child, while still under the jursidiction of a court or the care or custody of an agency as described in 106 CMR 504.210(A)(2), returns to the home of the relative and it is expected, subject to verification, that the child will remain in the home for more than 30 consecutive days, the child is considered to be living with the relative.

(4) The child will be considered to be living with the relative through the end of the calendar month in which the child was admitted to a long-term-care medical facility (e.g., pediatric nursing home or psychiatric hospital). The child is not considered to be living with the relative in the subsequent months in which he or she is receiving long-term care.

(B) Verification

The living arrangement of the child and the caretaker relative shall be verified only when the worker receives information that is contradictory to or inconsistent with that contained in the case record.

If verification is necessary, living arrangement is verified by school records showing the address of the child and the name of the relative who is responsible for the child. If this information is not available, living arrangement is verified by any one of the following:

(1) hospital or clinical records;

(2) Public Housing Authority records;

(3) court support orders;

(4) signed physician's statement;

(5) juvenile court records;

(6) Department of Social Services or Department of Youth Services records;

(7) voluntary social service agency records;

(8) Head Start program records; or

(9) day care center records.

504.300: Deprivation

A caretaker relative may establish eligibility for MA-AFDC if the child for whom he or she is responsible is deprived of parental care as described in 106 CMR 504.170. Deprivation can be established only with regard to the child's natural or adoptive parent.

A stepparent may elect to be included in the assistance unit as a needy spouse of the natural or adoptive parent who is the child's caretaker relative. If the stepparent is included in the assistance unit, his or her income and assets must be counted.

504.310: Death

(A) Requirements

A child may be considered deprived of care or support on the basis of the death of either parent.

(B) Verification

Death shall be verified at application or when necessary to establish death as the deprivation factor. The preferred source of verification of death is the death certificate. If this is not available, death is verified by one of the following:

(1) a signed statement from the funeral director;

(2) Veterans' Administration (VA) records;

(3) hospital records;

(4) records of other medical or long-term-care institutions;

(5) military service records;

(6) police records;

(7) social security survivor's claim records; or

(8) a newspaper death notice that clearly identifies the individual.

504.320: Continued Absence

(A) Requirements

(1) The continued absence of a parent constitutes deprivation when the absence interrupts or terminates the parent's functioning as a provider of maintenance, physical care, or guidance of the child, and the known or indefinite duration of the absence prevents the parent's performance of this function. An absence is of a continued nature if it has lasted, or can be expected to last, for a period of at least 20 days.

(2) A child is also considered to be deprived of parental support by reason of continued absence when:

a. the parent has been convicted of an offense and is under sentence of the court;

b. the parent is complying with the sentence that requires unpaid public work or community service during working hours; and

c. the parent is permitted by the court to live at home while serving the sentence.

(3) A child is considered not to be deprived of parental support by reason of continued absence if the parent's absence is occasioned solely by the performance of active duty in the uniformed services of the United States. The uniformed services are the following: Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanic and Atmospheric Administration, and the Public Health Service of the United States.

If the parent who is absent due to active duty in the uniformed services was living with the family prior to the current absence, it shall be assumed that the current absence is due solely to active duty in the uniformed services. If the absent parent has served in a succession of geographic locations with no interruption in service, the living arrangement that existed prior to the start of the absence will be used to determine whether the absence is due solely to active duty in the uniformed services.

The applicant or recipient may rebut this presumption by presenting verification that divorce, annulment, or separation proceedings have been started or documentation of abandonment of the child(ren) from the appropriate branch of the uniformed services.

A parent who is either Absent Without Leave (AWOL) from the uniformed services or incarcerated by the uniformed services is not considered to be absent due solely to active duty in the uniformed services and may be considered an absent parent.

(B) Verification

The continued nature of the absence of the parent, the reason for the absence, and the fact that the absence has lasted or clearly can be expected to last for a period of at least 20 days must all be verified.

(1) The continued nature of the absence of the parent must be verified at application or when establishing continued absence as a deprivation factor, at subsequent redeterminations, and whenever the Department has reason to question the continued absence of the parent. Acceptable verification is a current signed and dated statement from the applicant or recipient stating the date the parent left the home and that he or she continues to be absent from the home.

(2) The reason for the absence must be verified at application or when establishing continued absence as a deprivation factor. If the reason for the absence is unchanged, it does not have to be reverified. Any of the following sources, as appropriate, may be used to verify the reason for the absence.

a. In cases of incarceration, deportation, institutionalization, divorce, legal separation, annulment, orders for separate support, or where a complaint for divorce or separate support has been filed, official records are verification of the reason for the absence. Acceptable official records include those from a court, correctional institution, hospital, or the Immigration and Naturalization Service.

b. In cases of spousal or child abuse in which the abused spouse and children have left the home, documentation of the initiation of court action is acceptable verification of the reason for the absence.

c. In all other cases, the reason for the absence is verified by evidence of the parent's residence outside the home or by written statements by persons having a professional relationship with the applicant or recipient that support his or her claim about the absence.

d. If none of the above verifications are available, the reason for the absence is established and verified by the applicant's or recipient's signed and dated statement that the parent has left the home.

(3) If the reason for the absence can be verified by one of the sources listed in 106 CMR 504.320(B)(2)a., b., or c., it may be expected to last for a period of at least 20 days. If none of those verifications is available, an absence of less than 20 days is verified when it has lasted 20 days. If such an absence does prove to be continued, the deprivation requirement is met on the first day of the absence and MA/AFDC may be provided retroactively in accordance with 106 CMR 502.130: Application Activities and 106 CMR 502.160: Date of Eligibility.

(4) In cases where continued absence is due to a parent's performing court-ordered public service, documentation from the court or probation office is necessary to verify that:

a. the parent has been convicted of an offense and has been sentenced to unpaid public work or community service;

b. the parent is allowed to live at home; and

c. the parent is currently performing the service.

Also, documentation from the agency is necessary to verify the length of the sentence.

(5) To determine if an absence is due solely to active duty in the uniformed services, it must be determined whether the absent parent was or was not living with the family prior to the current absence. Any of the following verifications is acceptable provided the address of each parent at the time of the start of the absence is verified:

a. a signed statement from a landlord unrelated to the applicant or recipient or the absent parent;

b. church or religious institution records;

c. uniformed service records;

d. utility company records;

e. voter-registration records;

f. motor vehicle license or registration;

g. employment records; or

h. hospital or clinical records.

If the above verifications show that the family and the absent parent were living together prior to the current absence, the current absence shall be considered to be due solely to active duty in the uniformed services and the child(ren) shall not be considered to be deprived of parental support. The applicant or recipient may rebut this presumption by providing one of the verifications listed below:

a. divorce documents;

b. legal separation documents;

c. annulment documents;

d. orders for separate support;

e. complaint for divorce or separate support;

f. uniformed service records that verify the absent parent's incarceration or AWOL status; or

g. documentation of abandonment of the child(ren) from the appropriate branch of the uniformed services.

504.330: Physical or Mental Incapacity

(A) Requirements

A child is considered deprived of care or support if either parent, both of whom are living in the home, has a physicial or mental handicap, illness, or impairment that substantially reduces or eliminates the parent's ability to support or care for the child. The condition must have existed, or be expected to exist, for a period of at least 30 days.

If an incapacity has existed, or is expected to exist, for a period of six months, and when otherwise indicated, the applicant or recipient must inquire about and, where appropriate, apply for Social Security Disability Insurance (RSDI).

(B) Verification

Incapacity shall be verified at application and at redetermination or upon the expiration of the medical statement of incapacity, whichever is earlier.

Verification of incapacity is mandatory and shall be one of the following:

(1) evidence of eligibility for Social Security Disability Benefits (RSDI) or Supplemental Security Income (SSI) disability benefits;

(2) approval by the Department-designated disability determination unit (DDU); or

(3) the written statement of a Competent Medical Authority as defined in 106 CMR 501.500(H), dated within 45 days of the date of application or the date the redetermination form is received in the local office. The statement must indicate the expected duration of the incapacity.

504.340: Unemployment

A dependent child is considered deprived of care or support if the natural or adoptive parent who is the principal earner is unemployed. In order for the principal earner to be considered unemployed for eligibility purposes, he or she shall: be unemployed or underemployed; have a work history; have applied for unemployment compensation, unless he or she has not worked in the previous 12 months; and have not refused a bona fide offer of employment or training for employment, without good cause, within 30 days.

(A) Principal Earner

(1) Requirements

The principal earner is the parent who earned the greater amount of income of the two parents in the 24-month period immediately prior to application for benefits. If both parents earned an identical amount of income in the 24-month period, the Department shall designate which parent shall be the principal earner. Once the principal earner is identified, the designation may not be changed until the Medical Assistance case is closed and a new application has been made.

(2) Verification

Verification of principal earner status is mandatory. The 24 months of employment preceding application shall be verified by wage stubs, written statements from a former employer(s), or a copy of federal income tax returns. Both parents must submit this verification, regardless of when their relationship began. In instances when the parents cannot obtain the above verifications, the Department may designate the principal earner on the basis of the evidence that is available.

(B) Unemployment or Underemployment

(1) Requirements

The principal earner must have been unemployed or employed for less than 100 hours per month during the 30 days prior to receipt of Medical Assistance. The date of eligibility for Medical Assistance is the 31st day of unemployment or underemployment.

The principal earner may be eligible if employed more than 100 hours per month if the work is intermittent and the excess is of a temporary nature. The excess is temporary if the principal earner worked an average of fewer than 100 hours per month for the two months prior to the date of eligibility, as defined above, and is expected to work fewer than 100 hours during the next month.

(2) Verification

Verification of unemployment or underemployment is mandatory at application, at redetermination or when necessary to establish the deprivation factor. The applicant's or recipient's declaration containing the necessary information about employment status shall be sufficient verification.

Verification of underemployment showing the number of hours employed is mandatory and shall be by pay stubs or by a written statement from the employer or former employer.

(C) Work History

(1) Requirements

The principal earner meets the work history requirements if he or she:

a. has six or more quarters of work in which he or she received earnings of not less than $50 in each quarter, or has six or more quarters of participation in ET (or its predecessors) in a 13-calendar quarter period ending within one year prior to the application for Medical Assistance. Up to four of the required six work quarters may be met using full-time education in elementary or secondary school, or a vocational or technical course designed to prepare the individual for gainful employment, or an education or training program established under the Job Training Partnership Act; or

b. received unemployment compensation under an unemployment compensation law of a state or a possession of the United States at some time during the year prior to application for Medical Assistance; or

c. was qualified to receive unemployment compensation under an unemployment compensation law of a state or of the United States at some time during the year prior to application for Medical Assistance, but did not apply for unemployment compensation; or

d. performed work not covered by unemployment compensation, which, if covered, would have created eligibility for unemployment compensation within one year prior to the application for Medical Assistance.

NOTE: A "quarter of work" is a period of three consecutive calendar months ending on March 31, June 30, September 30, or December 31.

(2) Verification

Work history, or education counted toward meeting work history, shall be verified at application or when necessary to establish the deprivation factor. Work history shall be verified by pay stubs, W-2 forms, a written statement from a former employer(s), documents from an employment agency, or business records from self-employment. Education shall be verified by a transcript, report card, etc., or by a written statement from the school or organization operating the education or training course. The Department shall verify participation in ET or its predecessor.

(D) Unemployment Compensation

(1) Requirements

The principal earner must have applied for any unemployment compensation, unless he or she has not worked in the previous 12 months.

(2) Verification

Application for unemployment compensation shall be verified at application or when establishing unemployment as the deprivation factor. Verification is mandatory and shall be by documents of the Department of Employment and Training (DET) obtained by the applicant or recipient, or through collateral contact by the worker.

(E) Bona Fide Offer of Employment and Good Cause

(1) Requirements

The principal earner may not have refused a bona fide offer of employment or training for employment without good cause, as defined by 106 CMR 307.180(A), within the 30-day period prior to the first date of Medical Assistance eligibility.

(2) Verifications

Good cause shall be verified at application and when necessary to establish the deprivation factor in accordance with the provisions of 106 CMR 307.180(B).

504.500: SSI-Related Programs

Aged and disabled individuals shall establish eligibility for Medical Assistance as SSI-Related assistance units if they meet the requirements of one of the following programs:

(A) the SSI Program (recipients);

(B) the MA-Old Age Assistance Program;

(C) the MA-Disability Assistance Program;

(D) the Pickle Amendment provisions; or

(E) the Massachusetts Rehabilitation Commission-Personal Care Attendant Provisions. (These cases do not receive Federal Financial Participation.)

504.510: SSI Recipients: Automatic Eligibility

Persons who have met basic, categorical, and financial requirements under the Supplemental Security Income (SSI) Program are not required to make separate application for prospective Medical Assistance. However, if retroactive coverage is required, a separate application for retroactive Medical Assistance must be filed on a form prescribed by the Department.

(A) Eligibility Determination

SSI eligibility is determined by the Social Security Administration. The following persons qualify for Medical Assistance on the basis of current SSI eligibility:

(1) persons currently receiving SSI benefits; and

(2) the spouse of a recipient of SSI, or MA-Related to SSI, who was eligible for MA in December, 1973, as a spouse essential to care, will remain eligible for MA provided:

a. the recipient with whom the essential spouse lives continues to meet the December, 1973 Old Age Assistance and Disability Assistance eligibility standards; and

b. the spouse continues to live with the recipient as a spouse and remains essential to the care of the recipient and has no other income of his or her own.

(B) Extended Medicaid Eligibility Subsequent to Termination of SSI

An individual whose SSI assistance has been terminated shall continue to receive MA until a determination of ineligibility is made by the Department.

504.520: SSI-Related: MA-Old Age Assistance

Individuals aged sixty-five (65) or older may establish eligibility for Medical Assistance by making a separate application for the MA/OAA (Medical Assistance-Old Age Assistance) Program. Aged adults who may establish eligibility for MA/OAA include adults who would be eligible for SSI except for factors such as the following:

(A) the filing unit's total net income exceeds the SSI income limitation;

(B) the filing unit's total countable assets exceed the SSI asset limitation; or

(C) the applicant chooses not to apply or complete the application process for SSI eligibility.

504.530: SSI-Related: MA-Disability Assistance

Individuals who meet the Social Security Administration's definition of disability may establish eligibility for Medical Assistance by making a separate application for MA/DA (Medical Assistance-Disability Assistance). Disabled individuals who may establish eligibility for MA/DA include persons who would be eligible for SSI except for factors such as the following:

(A) the filing unit's total net income exceeds the SSI income limitation;

(B) the filing unit's total countable assets exceed the SSI asset limitation;

(C) the disabled individual, diagnosed as a drug addict or alcoholic, has refused to accept the SSI Program's referral for treatment at an appropriate facility; or

(D) the individual chooses not to apply or complete the application process for SSI eligibility.

504.540: SSI-Related: Pickle Amendment Cases

(A) Individuals determined to be ineligible for Supplemental Security Income benefits after April, 1977, may nevertheless be eligible for MA under certain circumstances.

(B) Under the Pickle Amendment, former SSI recipients are entitled to receive Medical Assistance for any month in which they would be eligible for SSI but for the amount of any RSDI cost-of-living increases received since the last month in which SSI benefits were received.

504.550: SSI-Related: Massachusetts Rehabilitation Commission-Personal Care Attendant Cases

An individual who is receiving at least 14 hours per week of Personal Care Attendant (PCA) services, provided and paid for by the Massachusetts Rehabilitation Commission (MRC), shall be eligible for Medical Assistance without regard to the SSI-Related financial or categorical eligibility requirements.

Eligibility for the PCA Program is determined by the MRC.

Verification that an individual is receiving PCA services is mandatory and shall be a statement from the Massachusetts Rehabilitation Commission.

504.560: SSI-Related: Disabled Widows and Widowers Applying Prior to 7/1/88

Individuals determined to be ineligible for Supplemental Security Income (SSI) benefits may establish eligibility for Medical Assistance provided they:

(A) have been continuously entitled to a monthly RSDI benefit under title II of the Social Security Act since December 1983;

(B) were entitled to and received a widow(er)'s benefit in January, 1984 based on a disability under section 202 (e) or (f) of the Social Security Act;

(C) had established entitlement to title II benefits prior to age 60;

(D) were eligible for SSI benefits prior to application of the new actuarial reduction formula revised by law but subsequently lost eligibility for SSI as a result of the change in that formula; and

(E) would be eligible for SSI benefits if the amount of the RSDI increase, and any subsequent cost-of-living adjustments in widow's or widower's benefits provided under the Pickle Amendment (see 106 CMR 504.540) were disregarded.

504.570: SSI-Related: Disabled Widows and Widowers

Individuals who lose eligibility for Supplemental Security Income (SSI) benefits because of receipt of Social Security title II benefits are deemed SSI recipients and continue to receive Medical Assistance until such time as they become eligible for Medicare provided they:

(A) apply for and receive early widow's or widower's benefits under section 202(e) or 202(f) of the Social Security Act, or under any other provisions of section 202 if they are also eligible under subsection (e) or (f) of section 202;

(B) are not entitled to Medicare Part A (hospital insurance); and

(C) are ineligible for SSI benefits under section 1616(a) of the Social Security Act because of receipt of title II benefits under section 202 of the Act, and would still be eligible for SSI in the absence of such title II benefits.

504.580: SSI-Related: Disabled Adult Children

Individuals who lose eligibility for Supplemental Security Income (SSI) benefits may retain eligibility for Medical Assistance provided they:

(A) are at least 18 years old;

(B) became blind or disabled before attaining the age of 22;

(C) receive(d) SSI benefits based on their blindness or disability;

(D) received an increase in child's insurance benefits under section 202(d) of the Social Security Act, or became entitled to those benefits on the basis of blindness or disability, on or after July 1, 1987;

(E) lose (or lost) SSI as a result of this entitlement or increase in child's insurance benefits under section 202(d) of the Social Security Act; and

(F) would still be eligible for SSI in the absence of such RSDI benefits or increase in benefits.

504.600: Age Sixty-five (65) or Older

(A) Requirements

As a condition of eligibility for MA-OAA, the individual shall be age sixty-five (65) years or older.

(B) Verifications

Verification of age is mandatory. Age shall be verified by one (1) of the following:

(1) Birth certificate;

(2) Hospital birth record;

(3) Bendex file record; or

(4) Social Security (RSDI) benefit records and Medicare card, pending Bendex file record.

If none of the above documents is available, two (2) of the following may be accepted, provided at least one (1) contains the date of birth and the other is dated and contains the age:

a. Family bible or genealogical records;

b. Baptismal certificate;

c. Insurance policies;

d. United States census records;

e. Immigration and Naturalization records;

f. Employment records;

g. Newspaper records and local histories;

h. Indian agency records;

i. Voluntary social service records;

j. Church records;

k. Passport record;

l. Other governmental records; or

m. An affidavit of a knowledgeable third person, if the applicant or recipient has demonstrated that he or she has tried unsuccessfully to obtain appropriate documents.

504.700: Permanent and Total Disability

(A) Requirements

As a condition of eligibility for MA-DA, the individual must be permanently and totally disabled as defined in subsection 501.500(II).

(B) Verifications

Verification of permanent and total disability for individuals under 65 is mandatory and shall be one of the following:

(1) a document from the Social Security Administration certifying eligibility or receipt of Social Security Disability Benefits (RSDI); or

(2) a document from the Department's disability determination unit (DDU) certifying that the individual is disabled.

The applicant or recipient shall cooperate with DDU to obtain any required medical information or records.

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505.000 Overview of Financial Requirements

In addition to meeting basic and categorical requirements, all Medical Assistance applicants and recipients must meet certain financial eligibility requirements. The applicant or recipient is required to submit any document that is relevant to verify either his or her current financial status or factors that may have an affect on financial status, in determining Medicaid eligibility. This includes, but is not limited to, bank accounts, wage stubs, income tax returns, deeds, etc.

Unless specifically stated otherwise, the requirements of this section apply to both AFDC-Related and SSI-Related filing units.

505.100: Countable and Noncountable Assets

Countable assets are all assets that are considered for eligibility determination. Noncountable assets are all assets that are exempt from consideration. All assets are considered countable unless inaccessible in accordance with 106 CMR 505.150 or unless exempted herein. Assets must be distinguished from income as defined in 106 CMR 505.200.

505.110: Asset Limitation

The total value of countable assets owned by, or available to, persons in the filing unit may not exceed the following:

1 Person	$2,000
2 Persons	$3,000
Each Additional Person	$ 100

There is no asset limitation for filing units that include:

(1) children aged one through five whose income is less than or equal to 133% of the federal-poverty-level income standards in 106 CMR 506.430; or

(2) a pregnant woman and her unborn child(ren), or a child(ren) under age one, whose income is less than or equal to 185% of the federal-poverty-level income standards in 106 CMR 506.430.

505.115: Asset Reduction

(A) Criteria

(1) An applicant whose assets exceed the asset limitation in Section 505.110 may become eligible for Medical Assistance if:

(a) he or she incurs allowable medical bills (see Section 506.540) that equal or exceed his excess assets; and

(b) he or she reduces his or her excess assets to the allowable asset limitation within the time period permitted by subsection (C) without violating the provisions of Section 505.120; and

(c) he or she is otherwise eligible for Medical Assistance.

(2) The Department shall not be responsible for payment of that portion of the medical bills equal to the amount of the excess assets.

(3) The bills used to establish eligibility cannot be incurred earlier than the first day of the third month prior to the date of the application that was or eventually will be approved and may not be the same portions of the bills that are used to meet an income spenddown.

(B) Date of Eligibility

(1) An individual who meets the eligibility requirements of this section and is otherwise eligible will be eligible as of the date his or her incurred allowable medical expenses equalled or exceeded the amount of his or her excess assets.

(2) If an individual submits an allowable bill for a previous date of medical service in accordance with 505.115 (A) (3), the Department shall readjust the date of eligibility.

(3) In no event shall the first day of eligibility be earlier than the first day of the third month prior to the date of the application that was subsequently approved.

(C) Verification

The applicant will be required to verify that he or she incurred the necessary amount of bills and that his or her excess assets were reduced to the allowable asset limitation. If the applicant is notified that he or she has excess assets, and if the applicant subsequently verifies the asset reduction within 30 calendar days of the date of the notification of the amount of excess assets, the worker shall make a second eligibility determination based on the original date of application.

(D) Recipients

This section also applies to recipients whose Medical Assistance has been terminated due to excess assets.

505.120: Transfer of Assets Prior to April 1, 1990

(A) Requirements

In determining assets available to an individual applying for or receiving Medical Assistance, any asset, or interest in an asset, owned by a member of the filing unit shall be considered available if the individual assigned or transferred such asset or interest at less than fair market value in the preceding 24 months for the purpose of obtaining or maintaining eligibility for Medical Assistance, except as provided in 106 CMR 505.120. The provisions of 106 CMR 505.120 shall apply only to transfers made prior to April 1, 1990. The value of such an asset or interest in the asset shall be the equity value of the asset or interest in the asset at the time of the transfer, less the amount of compensation received, if any.

When funds are transferred from a bank account, of which the applicant or recipient is a joint owner, the amount of the applicant or recipient's ownership interest shall be determined in accordance with 106 CMR 505.160(B). If, after the provisions of 106 CMR 505.160(B) have been applied, it is determined that funds owned by the applicant or recipient were transferred with his or her consent and knowledge, such transfer shall be deemed a transfer by the applicant or recipient, regardless of who actually transferred the funds, and the uncompensated value of the amount transferred shall be considered under the provisions of 106 CMR 505.120(B) through (E).

(B) Exclusions

The Department shall document but not deny or terminate assistance in the following situations.

(1) The filing unit's total countable assets, including the equity value of the property transferred, is less than the allowable asset limit. The value of the property at the time of the transfer is used in the calculation.

(2) The applicant or recipient received adequate consideration for the value of the property at the time of the transfer. Adequate consideration exists if:

a. the applicant or recipient received fair market value for the asset;

b. the transfer was made to satisfy a legally enforceable debt; or

c. the transfer was made to reimburse someone other than a legally responsible person for care or benefits provided on the understanding that reimbursement would be made by the applicant or recipient.

d. funds were transferred to a separate and identifiable burial account in accordance with 106 CMR 505.170(0); or

e. the applicant or recipient (or his or her spouse) is the beneficiary of an annuity that is actuarially equal in value to the transferred asset (purchase price).

(C) Determination of Intent

If the transfer was not in accordance with the provisions of 106 CMR 505.120(B), the Department must demonstrate that the applicant or recipient had the intent of obtaining or maintaining eligibility for Medical Assistance at the time of the transfer.

Eligibility for Medical Assistance shall be denied or terminated when the Department determines that the intent to obtain or maintain eligibility for Medical Assistance existed at the time of the transfer.

In determining intent, the worker shall review all of the circumstances surrounding the transfer. This determination shall include consideration of any of the following factors which may be relevant to those circumstances:

(1) whether the applicant or recipient had knowledge of the Medical Assistance asset eligibility requirements, including these transfer of asset regulations;

(2) whether given the applicant or recipient's age, health, other assets and income, and life expectancy, he or she retained sufficient assets at the time of the transfer to provide for his or her foreseeable needs for support and medical care;

(3) whether the applicant or recipient was coerced or misled in any way into making the transfer;

(4) what the type, source and disposition of the transferred asset were;

(5) whether the applicant or recipient reported the transfer or it was discovered through other means;

(6) whether there was another reasonable purpose for the transfer.

(D) Eligibility Reinstatement

An individual who is found ineligible or has become ineligible because of a transfer of countable assets shall become eligible when:

(1) he or she incurs medical bills, for which he or she is liable, equal to the countable value of the transferred asset and for

which government or insurance payments are not available, provided that these bills may not also be used as incurred medical expenses for the purpose of meeting any spenddown liability; or

(2) 24 months have elapsed since the month of the transfer.

(E) Hardship

The period of ineligibility may be waived for those individuals who would suffer undue hardship because the application of these provisions would (1) require that an individual remain in an institution instead of the community; or (2) place the individual in a life-threatening medical emergency or in extreme danger of physical or mental deterioration as verified by a competent medical authority and there is no available alternative.

505.125: Transfer of Assets - Nursing Facility Services

(A) Requirements

For the purpose of obtaining or maintaining eligibility of an institutionalized person for payment of nursing facility services, for a level of care in a medical institution equivalent to that of nursing facility services, or for home and community based waiver services, any asset or interest in an asset owned by a member of the filing unit or his or her spouse shall be considered available if the individual or the individual's spouse assigned or transferred such asset or interest at less than fair market value beginning on or after April 1, 1990, except as provided in this section. The value of such an asset or interest in the asset shall be the equity value of the asset or interest in the asset at the time of the transfer, less the amount of compensation received, if any.

The provisions of 106 CMR 505.125 shall apply to transfers made at any time during or after the 30-month period immediately preceding the date of application or the date of institutionalization, whichever is later. An individual is considered institutionalized for the purpose of 106 CMR 505.125 if the individual is an inpatient in a nursing facility, on administrative days, or on SNF search status in a medical institution, or is receiving Medical Assistance under the provisions of 106 CMR 505.450(A)(1)a.

When funds are transferred from a bank account, of which the applicant or recipient (or the spouse of the applicant or recipient) is a joint owner, the amount of the individual's ownership interest shall be determined in accordance with 106 CMR 505.140(C). If, after the provisions of 106 CMR 505.140(C) have been applied, it is determined that funds owned by the applicant or recipient (or the spouse of the applicant or recipient) were transferred with his or her consent and knowledge, such transfer shall be deemed a transfer by the applicant or recipient or his or her spouse, regardless of who actually transferred the funds, and the uncompensated value of the amount transferred shall be considered under the provisions of 106 CMR 505.125(B) through (E).

If a recipient, whose estate would be subject to a claim under 106 CMR 502.900, transfers or sells a home for less than fair market value, the Department may consider such a transfer or sale, that does not meet the conditions under 106 CMR 505.125(B)(3), to be fraudulent under the Uniform Fraudulent Conveyance Act (G.L.c 109A) and take appropriate legal action to set aside the transfer or sale.

(B) Exclusions

The Department shall document but not deny or terminate assistance because of a transfer of assets in the following situations.

(1) The filing unit's total countable assets, including the equity value of the property transferred, is less than the allowable asset limit. The value of the property at the time of the transfer is used in the calculation.

(2) The applicant or recipient (or his or her spouse) received adequate consideration for the value of the property at the time of the transfer. Adequate consideration exists if:

a. the applicant or recipient (or his or her spouse) received fair market value for the asset;

b. the transfer was made to satisfy a legally enforceable debt;

c. the transfer was made to reimburse someone other than a legally responsible person for care or benefits provided on the understanding that reimbursement would be made by the applicant or recipient (or his or her spouse);

d. funds were transferred to a separate and identifiable burial account in accordance with 106 CMR 505.170(O); or

e. the applicant or recipient (or his or her spouse) is the beneficiary of an annuity that is actuarially equal in value to the transferred asset (purchase price).

(3) The applicant or recipient transferred a home used as the principal residence at the time of the transfer and the title to the home was transferred to:

a. his or her spouse;

b. his or her child who is under age 21, or who is blind or permanently and totally disabled;

c. his or her sibling who has an equity interest in the home and was residing in the home for a period of at least one year immediately before the date of the individual's admission to the institution; or

d. his or her child (other than the child described in 106 CMR 505.125(B)(3)b.), who was residing in the applicant's or recipient's home for a period of at least two years immediately before the date of the applicants's or recipient's admission to the institution, and who (as determined by the Department) provided care to the applicant or recipient that permitted him or her to reside at home rather than in an institution.

(4) The assets, except for the transfer of a home that met one of the conditions in 106 CMR 505.125(B)(3), were transferred:

a. to the applicant's or recipient's spouse (or to another for the sole benefit of the applicant's or recipient's spouse). Transfers made following an eligibility determination must be performed within 90 days in accordance with the provisions of 106 CMR 505.180(D);

b. from the spouse to the institutionalized spouse (or to another for the sole benefit of the institutionalized spouse); or

c. to his or her blind or permanently and totally disabled child.

(C) Determination of Intent

For the Department to determine that an institutionalized applicant or recipient of long-term-care services is not ineligible for an appropriate period of time due to any transfer that was not in accordance with the provisions of 106 CMR 505.125(B), the applicant or recipient (or his or her spouse) must demonstrate to the satisfaction of the Department:

(1) that he or she intended to dispose of the resources either at fair market value, or for other valuable consideration; or

(2) assets that are countable, in accordance with 106 CMR 505.160, were transferred exclusively for a purpose other than to qualify for Medical Assistance.

(D) Period of Ineligibility

The period of ineligibility shall begin with the month in which the assets were transferred and the number of months in such period shall be equal to the lesser of the following:

(1) the number of months that result when the total value of the assets transferred, divided by the average monthly cost of private nursing home care in the Commonwealth at the time of the application as determined by the Department, have elapsed; or

(2) 30 months.

(E) Hardship

The period of ineligibility may be waived for those individuals who would suffer undue hardship because the application of these provisions would: (1) require that an individual remain in an institution instead of the community; or (2) place the individual in a life-threatening medical emergency or in extreme danger of physical or mental deterioration as verified by a competent medical authority and there is no available alternative.

505.130: Recipient's Receipt of Property

A recipient who, by gift, inheritance, or other manner, acquires additional assets during his or her period of eligibility shall report such acquisition within 10 calendar days for a reevaluation of his or her eligibility.

505.140: Ownership of Assets

(A) General

Assets owned exclusively by a member of a filing unit applying for or receiving Medical Assistance are counted in their entirety when determining eligibility for Medical Assistance, except when assessing assets in accordance with 106 CMR 505.180.

(B) Joint Ownership of Assets, Other Than Bank Accounts

Any asset, other than a joint bank account, jointly owned by two or more persons, is presumed to be owned in equal shares and counted proportionately unless a different distribution of ownership is verified or unless assets are being assessed in accordance with 106 CMR 505.180. When such a different distribution of ownership is verified, the countable value of the assets shall be attributed to each filing unit member in proportion to the ownership interest.

(C) Joint Bank Accounts

(1) When a member of a filing unit applying for or receiving Medical Assistance is a joint owner of a bank account, the entire amount on deposit shall be considered available to the filing unit, except when assessing assets in accordance with 106 CMR 505.180.

(2) If a member of a filing unit, applying for or receiving Medical Assistance, claims partial ownership of the funds in the joint account, he or she shall verify the amount owned by each joint depositor. When such a partial ownership is verified, the countable value of the assets shall be attributed to each filing unit member in proportion to the ownership interest.

(3) The filing unit may transfer the funds owned by him or her into an account that accurately reflects the ownership interest of the applicant or recipient. Such a transfer shall not be considered a transfer of assets to make oneself eligible for Medical Assistance if completed within 30 days of written notification by the Department of this requirement.

(D) Verifications

Verification of ownership, individually or jointly, is mandatory and shall be one or more of the following:

(1) Title;
(2) Purchase contract;
(3) Documents establishing ownership of joint bank accounts that demonstrate:

a. The origin of the funds in a joint bank account, who opened the account, or whose money was used to open the account;

b. Federal and state tax records as to which joint account holders pay the tax on interest credited to the account as income;

c. Records of who makes deposits and withdrawals and, if appropriate, how withdrawn funds are spent;

d. Any evidence of written or oral agreements made between the parties at the time of the creation of the account;

e. When the applicant or recipient states that he or she does not own the account but is listed as a co-holder solely as a convenience to the other co-holder to conduct bank transactions on his or her behalf, evidence of age, relationship, physical or mental condition, or place of residence of the co-holders shall be provided; or

f. Why the applicant or recipient is listed on the account;

(4) Certification of ownership;

(5) Financial institution records indicating the establishment of an account that accurately reflects the ownership interest of funds from the joint account;

(6) Other documentation that indicates ownership, asset value, and restrictions on access; or

(7) A notarized affidavit, sworn to under penalty of perjury, signed by all owners of the asset attesting to the distribution of ownership.

If an applicant or recipient would be required to pay to obtain documents or other verification, and no other method of verification is available, the Department, if it determines the document is necessary, shall obtain the document.

505.150: Inaccessible Assets

(A) Requirements

An inaccessible asset is an asset to which the applicant or recipient has no legal access and is not counted when determining eligibility for Medical Assistance for the period it is inaccessible or is deemed to be inaccessible under this section.

(1) Inaccessible assets include, but are not limited to, property the ownership of which is the subject of legal proceedings (e.g., probate, divorce suits, etc.); and the cash surrender value of life insurance policies when the policy has been assigned to the issuing company for adjustment.

(2) All assets to which the applicant or recipient is legally entitled shall be considered accessible to the applicant or recipient:

(a) from the date of application or acquisition, whichever is later, if the applicant or recipient does not meet each condition stated in 106 CMR 505.150(A)(2)(b)(i) or (ii); or

(b) from the period beginning six months after the date of application or acquisition, whichever is later if:

(i) the applicant or recipient is incapable of competently representing his or her own interests, has no guardian or conservator capable of representing the applicant's or recipient's interests, and the representative (which may include a provider) of such applicant or recipient is making a good faith effort to secure the appointment of a competent guardian or conservator; or

(ii) the sole trustee of a Medicaid Qualifying Trust, under 106 CMR 505.160(J), is one whose whereabouts are unknown or who is incapable of competently fulfilling his or her fiduciary duties, and the applicant or recipient, directly or through a representative (which may include a provider), is making a good faith effort to contact the missing trustee or to secure the appointment of a competent trustee.

(B) Verifications

The verification of the inaccessibility of an asset is mandatory and shall be:

(1) A copy of the original legal instrument that established the inaccessibility of the asset;

(2) Relevant legal or financial statements that document the inaccessibility of the asset, if the original legal instrument is not available;

(3) Bank documents showing how the account holder's name(s) appears on the account, such as:

a. If the account is titled A or B, both individuals have full access to the account;

b. If the account is titled A and B, neither individual has access to the account without the consent of the co-holder. The applicant or recipient must submit a written statement from the co-holder denying such consent. If the applicant or recipient is unable to obtain such a statement, he or she may submit an affidavit stating that he or she does not have the co-holder's consent.

c. If the account is titled A in trust for B, or A for B, A has full access to the account and B has no access to the account unless prior to establishing the account the assets that are now in the account were owned by B (see 106 CMR 505.140(D)).

If B had owned the assets and is the applicant for or recipient of Medical Assistance, such a transfer would constitute either:

(i) a disqualifying transfer of assets; or
(ii) the creation of a Medicaid Qualifying Trust.

d. If the account title contains only one name, that individual has full access to the account.

The verification of the temporary inaccessibility of any asset under 106 CMR 505.150(A)(2)(b) is mandatory and shall include:

(4) A written statement from a competent medical authority verifying that, and describing the medical reason(s) why,

(a) the applicant or recipient is incapable of competently representing his or her own interests; or

(b) the guardian or conservator, if any, is incapable of competently representing the applicant's or recipient's interest; or

(c) the sole trustee of a Medicaid Qualifying Trust is incapable of competently fulfilling his or her fiduciary duties.

(5) A written statement sworn to and signed under the pains and penalties of perjury by the applicant's or recipient's representative attesting to and describing the good faith efforts to secure the appointment of a competent guardian or conservator for the applicant or recipient.

(6) A written statement sworn to and signed under the pains and penalties of perjury by the applicant or recipient, or his or her representative

(a) attesting to the unknown whereabouts of the sole trustee of a Medicaid Qualifying Trust, and attesting to and describing the good faith efforts to contact such trustee; or

(b) attesting to and describing the good faith efforts to secure the appointment of a competent trustee.

If an applicant or recipient demonstrates lack of ownership, inaccessibility to the asset or both, the asset is not considered in the determination of eligibility.

505.160: Countable Assets

Countable assets are all assets that must be included in the determination of the total value of assets. Assets that shall be taken into consideration in determining total countable assets include, but are not limited to, the following.

(A) Cash

(1) Requirements

Cash is currency, checks, or bank drafts in the possession of, or available to, the filing unit.

(2) Verification

The amount of cash shall be counted at application, at redetermination, and when a change is reported.

The applicant's or recipient's declaration on the application or redetermination form stating the amount of cash available to the filing unit shall be sufficient evidence.

(B) Bank Deposits

(1) Requirements

Bank deposits are deposits in a bank, savings and loan institution, or credit union or other financial institution. Bank deposits may be in the form of savings, checking or trust accounts, term certificates, or other types of accounts.

Funds in a bank account shall be considered available only to the extent that the applicant or recipient has both ownership of and access to such funds. The determination of ownership of and access to the funds shall be determined in accordance with 106 CMR 505.140 and 505.150.

(2) Verification of Account Balances

Verification of the current balance of each account is mandatory at application, at redetermination, and at times of reported change.

For noninstitutionalized persons, the amount on deposit shall be verified by bank books or bank statements that show the bank balance within 45 days of the date of application or the date the redetermination form is received in the local office.

For institutionalized persons, the amount on deposit shall be verified by bank books or bank statements that show the current balance and account activity during the 30-month period prior to the date of application. For purposes of 106 CMR 505.160(B), an institutionalized person is an individual who is an inpatient in a nursing facility or a hospitalized individual on administrative days.

If at redetermination the recipient states either orally or in writing a balance of $25 or less in an account, other than a checking account, verification shall not be required provided a balance of $25 or less was verified for the same account at the last eligibility determination and the account balance, in combination with other countable assets, would not affect continued eligibility. The recipient's oral declaration shall be recorded in the case record.

If lack of either access to, or ownership of, funds in an account is verified, the funds shall not be considered a countable asset.

(C) Individual Retirement Accounts, Keogh Plans, Pension Funds, and Annuities

(1) IRAs and Keogh Plans

An Individual Retirement Account (IRA) is a tax deductible savings account that sets aside money for retirement. Funds in an IRA are counted as an asset in their entirety less the amount of penalty for early withdrawal.

A Keogh Plan is a retirement plan established by a self-employed individual. A Keogh Plan may be established for the self-employed individual alone or for the self-employed individual and his or her employees. If the Keogh Plan was established for the self-employed individual alone, the funds in the Plan are counted as an asset in their entirety less the amount of penalty for early withdrawal. If the Keogh Plan was established for employees who are not members of the filing unit as well as for the self-employed individual, the funds are not counted as an asset.

(2) Pension Funds

Pension funds are retirement plans, established by employers to provide benefit payments to their employees upon retirement or disability. Pension funds that are being set aside by an individual's current employer shall not be countable as an asset. Pension funds from an individual's former employer shall be countable in their entirety less any penalties for withdrawal provided such funds are accessible. (See 106 CMR 505.150: Inaccessible Assets.)

(3) Annuities

An annuity is an investment that provides a fixed sum payable to a person, based upon the terms of the annuity. Payments may be made for a specific period of time or for life. If the annuity can be converted to a lump sum, the lump sum, less any penalties or costs of converting to a lump sum, shall be considered a countable asset.

Purchase of an annuity shall be considered a disqualifying transfer of assets without adequate consideration when (1) the beneficiary is other than the applicant or recipient (or his or her spouse) or (2) the annuity is not actuarially equal in value to the transferred asset (purchase price). In this case the value of the disqualifying transfer will be determined based on actuarial value of the annuity compared to the beneficiary's life expectancy.

Payments from an annuity shall be considered countable income in accordance with 106 CMR 505.220.

(4) Verification

Verification of the current value of the IRA, Keogh Plan, pension fund or annuity is mandatory at application, redetermination and when a change in circumstances is reported. The original purchase value of the annuity shall also be verified at application.

The amount of the funds available to the applicant or recipient shall be verified by a written statement from the financial institution or employer dated within 45 days of the application date or the date the redetermination form is received in the local office.

(D) Personal Needs Allowance (PNA) Account

(1) Requirements

A personal needs allowance (PNA) account is an account administered by a long-term-care facility on behalf of a recipient.

(2) Verification

Verification of the current balance of the PNA account is mandatory at application, redetermination, and at times of reported change.

The amount in the PNA account shall be verified by a written statement from the bank or facility where the account is maintained, dated within 45 days of the application date or the date the redetermination form is received in the local office.

(E) Securities

(1) Requirements

Securities are stocks, bonds, options, futures contracts, debentures, mutual and money market funds, shares, government, bank, corporate or promissory notes, and other financial instruments. Tradeable securities are valued at the most recent closing bid price, and nontradeable securities are valued at current equity value. A security for which there is no market or which is inaccessible in accordance with 106 CMR 505.150 is noncountable.

(2) Verification

Verification of the current value of each security is mandatory at application, redetermination, and when a change is reported. The number of securities owned shall be substantiated by the written statement of the applicant or recipient.

Any one of the following shall be sufficient verification of the value of the security:

(a) a statement from the individual, corporation, licensed stockbroker, bank, or government agency that issued the security;

(b) a clipping from a current daily newspaper showing the date and closing bid price;

(c) a statement from any bank or other financial services institution able to verify the current value of a particular security; or

(d) documentation from a current financial publication.

A claim that a particular security has no market value shall be verified by one of the verifications listed above. A claim that a security is inaccessible shall be verified in accordance with 106 CMR 505.150.

(F) Cash Surrender Value of Life Insurance Policies

(1) Requirements

The cash surrender value of a life insurance policy is the amount, if any, that the issuing company has agreed to pay the owner of the policy upon its cancellation.

An individual may adjust the cash surrender value of life insurance to meet the asset limitation. The Department shall consider the cash surrender value amount an inaccessible asset during the adjustment period.

(a) AFDC-Related Filing Units

The total cash surrender value of all life insurance policies owned by a member of an AFDC-related filing unit is a countable asset unless exempted for funeral and burial expenses in accordance with 106 CMR 505.170(0).

(b) SSI-Related Filing Units

If the total face value of all countable life insurance policies owned by a filing unit member exceeds $1,500, the total cash surrender value of all policies held by that person is countable.

The face value of burial insurance and the face value of life insurance policies not having a cash surrender value (e.g., term insurance) shall not be taken into account in determining the total face value of life insurance policies. Burial insurance is insurance whose terms specifically provide that the proceeds can be used only to pay the burial expenses of the insured.

(2) Verifications

The verification of the face value and cash surrender value of all countable life insurance policies is mandatory at application and when a change has occurred. Cash surrender value must also be reverified at least once a year.

The face value and cash surrender value shall be verified by the Table of Loan and Cash Surrender Value amounts located on the actual policy, or a written statement from the issuing company or its representative. If the total cash surrender value of all countable policies owned by the filing unit, combined with the value of all other countable assets, is within $150 of the asset limit, or if the policy is paid up or has been in effect longer than the number of years covered by the table, the cash surrender value must be verified by a written statement from the issuing company or agent.

(G) Vehicles

(1) Requirements

AFDC-Related

One vehicle per filing unit shall be exempt from having its equity value counted as an asset, provided it is used primarily for transportation purposes. The equity value of all vehicles owned by the filing unit, including vehicles that are used primarily for recreational purposes such as snowmobiles, boats, trailers, jeeps, vans, and motorcycles, shall be countable. The exempt vehicle shall be the one selected by the filing unit.

SSI-Related

In determining the resources of an individual (and his or her spouse, if any), vehicles are noncountable or countable as follows:

(a) One vehicle is noncountable regardless of its value if, for the individual or a member of the individual's household:

1. it is necessary for employment;

2. it is necessary for the medical treatment of a specific or regular medical problem;

3. it is modified for operation by or transportation of a handicapped person; or

4. it is necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

(b) If no vehicle is excluded under 106 CMR 505.160(G)(1)a., one automobile is noncountable if its equity value does not exceed $4,500. If the equity value of the automobile exceeds $4,500, the excess is countable toward the applicant or recipient's asset limit.

(c) All vehicles other than those described in 106 CMR 505.160(G)(1)(a) or (b) are countable assets.

(2) Exemption for SSI-Related Vehicles

In an SSI-related filing unit, the value of nonexempt vehicles is noncountable for three months provided the applicant or recipient signs an agreement with the Department to dispose of the vehicle(s) at fair market value.

An additional three-month extension may be granted if good cause is found for the failure to dispose of the property within the initial three-month period. Good cause exists when the disposition was prevented by the occurrence of an event beyond the control of the applicant or recipient and the individual was making a bona fide effort to dispose of the property during the initial three-month period.

The proceeds from the sale of the vehicle after payment of loans or other encumbrances are considered a countable asset in the month received and in subsequent months. The equity value of a vehicle that has not been sold after three months from the date of the written agreement (or six months from the date of the written agreement if an extension has been granted) shall be a countable asset, and eligibility shall be redetermined.

(3) Verification

The equity value and fair market value of all countable vehicles shall be verified at application and when another vehicle is acquired. Equity value and fair market value shall also be verified at redetermination if the Department has reason to believe that the value has increased or changed so that, combined with other assets, the value affects or may affect continued eligibility.

(a) Equity Value

Equity value is determined by subtracting the balance of any loans, liens, or legal encumbrances from the fair market value of the vehicle.

The balance of an outstanding loan shall be verified by the payment book or a statement from the bank, finance company, or lender showing the payment schedule and the outstanding balance.

(b) Fair Market Value

Fair market value is the price for which the vehicle will sell on the open market.

The fair market value shall be verified by one of the following and in the following order of preference:

1. the wholesale value (for cars and trucks) and finance value (for recreational vehicles) tables in the most recent vehicle valuation book that is used by the Department;

2. the low value in an older car valuation book (for cars and trucks); if the car or truck is too old to be listed in an older car valuation book, it shall be assigned a value of $250;

3. the written appraisal of a licensed automobile dealer who deals with classic, custom-made, or antique vehicles, if the vehicle is considered a classic, custom-made, or antique; or

4. for recreational vehicles the projected loan value as quoted by a bank or other lending institution; documents showing the value of the vehicle for insurance purposes; or a written estimate of the cash value of the vehicle from a licensed recreational vehicle dealer.

If the fair market value, as determined in 106 CMR 505.160(G)(3)(b) 1 through 4 above, in combination with other assets, exceeds the Medical Assistance asset limitation, the Department shall notify the household of the method by which the value was determined and the procedures to rebut the valuation.

If a vehicle is specially equipped with apparatus for the handicapped, has other optional equipment, or has low mileage, these factors shall not increase the value of the vehicle.

The applicant or recipient may rebut the valuation assigned by the Department by submitting evidence such as the written estimate of a licensed automobile dealer; at least two current newspaper advertisements showing the amount for which similar vehicles are being sold; or a more recent and/or different vehicle valuation book.

(c) Ownership

When joint ownership by two or more persons is claimed, verification of ownership of the vehicle shall be mandatory at application and when a change regarding joint ownership of vehicles is reported.

Ownership and distribution of ownership shall be determined and verified in accordance with 106 CMR 505.140.

(H) Real Estate Other Than the Principal Place of Residence - AFDC-Related

(1) Requirements

The equity value of all real estate owned by a member(s) of the filing unit is a countable asset unless it is the principal place of residence of the filing unit as described in 106 CMR 505.170(A).

The equity value of real estate that is not the principal place of residence is noncountable for nine months from the date of application or acquisition, whichever is later, provided the applicant or recipient is making a good faith effort to dispose of the property at or about fair market value.

Proceeds from the liquidation, after payment of loans, liens, or other encumbrances, are considered a countable asset in the month received and in subsequent months. The equity value of real estate that has not been liquidated after nine months from the date of application or acquisition shall be a countable asset, and eligibility shall be redetermined.

(2) Verifications

The fair market value and equity value of all countable real estate owned by the filing unit must be verified at application and at times of reported change when it affects or may affect eligibility.

Fair market value shall be verified by a copy of the most recent tax bill or the property tax assessment that was most recently issued by the taxing jurisdiction provided this assessment is not:

- a special-purpose assessment;
- based on a fixed-rate-per-acre method; or
- based on an assessment ratio or providing only a range.

In the event that a current property tax assessment is not available or the applicant or recipient wishes to rebut the fair market value determined by the Department, a comparable market analysis or a written appraisal of the value of the property from a knowledgeable source shall establish the fair market value. A knowledgeable source shall be a licensed real estate agent or broker, a real estate appraiser, bank, savings and loan association or similar lending organization, or an official of the local real properly tax jurisdiction.

If the lender is an organization, the verification of encumbrances or legally enforceable obligations on the property shall be a copy of loan instruments, or other binding documents that evidence the outstanding balance of the loan. If the lender is an individual, the amount of the encumbrances or obligations shall be verified by a copy of the loan instrument and a signed statement from the lender setting forth the payment schedule and outstanding balance of the loan or other documents that evidence the outstanding balance of the loan.

The applicant's or recipient's good faith effort to dispose of real property other than that used as the principal place of residence must be verified at application and at redetermination by evidence such as advertisements or documentation of the listing with licensed real estate agents or brokers, including a report of any offer from prospective buyers.

(3) Lien

The Department will place a lien prior to the death of a recipient against any real estate in which the recipient has ownership interest. This lien will be placed only if all of the conditions of 106 CMR 502.910 are met.

(I) Real Estate Other Than the Principal Place of Residence - SSI-Related

(1) Requirements

All real estate owned by members of the filing unit, other than the principal place of residence as described in 106 CMR 505.170(A) as well as business or nonbusiness property as provided in 106 CMR 505.170(K), are countable assets.

The value of such real estate is exempt for nine months from the date of notice by the Department provided the individual signs an agreement with the Department within 30 days of the date of notice to dispose of the property at fair market value. The nine-month period can be extended as long as the applicant or recipient continues to make a good faith effort to sell as verified in accordance with 106 CMR 505.160(I)(5)(b).

The proceeds from the liquidation of such real estate, after payment of loans, liens, or other encumbrances, are considered a countable asset in the month received and in subsequent months.

If a recipient fails to report acquisition of a piece of real estate within 10 days of taking title to the real estate and the equity value of the real estate, when added to all other countable assets, exceeds the MA asset standard, the Department has the right to recover overpayment in accordance with 106 CMR 502.820.

(2) Former Home

If an individual (and spouse, if any) moves out of his or her home for reasons other than institutionalization without the intent to return, the home becomes a countable asset because it is no longer used as the individual's principal place of residence. It is subject to the same requirements to liquidate as described in 106 CMR 505.160(I)(1).

(3) Former Home of Individual in a Medical Institution

If an applicant or recipient moves out of his or her home to enter a medical institution, the Department shall consider the applicant or recipient's former home as a countable asset when all of the following conditions are met.

(a) The individual is an inpatient receiving long-term or chronic care in a nursing facility or other medical institution.

(b) None of the following relatives of the applicant or recipient are residing in the property:

1. a spouse;

2. a child who is under age 21 or who is blind or permanently disabled;

3. a sibling who has an equity interest in the home and who was residing there for a period of at least one year immediately before the applicant or recipient's admission to the medical institution;

4. a son or daughter who was residing in the applicant or recipient's home for a period of at least two years immediately before the date of the applicant's admission to the medical institution, and who establishes to the satisfaction of the Department that he or she provided care to the applicant or recipient that permitted the applicant or recipient to reside at the home rather than an institution; or

5. a dependent relative. A dependent relative is any of the following who have any kind of dependency (such as medical or financial):

- o child, stepchild, or grandchild:
- o parent, stepparent, or grandparent;
- o aunt, uncle, niece or nephew;
- o brother or sister, stepbrother or stepsister, half brother or half sister;
- o cousin; or
- o in-law.

(c) The individual (and spouse, if any) moves out of his or her home without the intent to return.

(d) The individual does not own long-term-care insurance whose coverage meets the requirements of 211 CMR 65.00.

Instead of selling the countable former home, the individual may opt to liquidate the equity value of his or her countable former home to pay for his or her medical care. If the individual chooses this option, the home will be noncountable until the equity value is liquidated but not longer than nine months from the date of Department notice.

(4) Undue Hardship - Definition

The Department shall continue to exclude otherwise countable property, including a former home that is otherwise countable, when it is jointly owned and sale of the property by an individual would cause the other owner(s) to lose housing.

Loss of housing would result when the property serves as the principal place of residence for one (or more) of the other owners, and sale of the property would result in loss of that residence, and no other housing would be readily available for the displaced other owner. However, if undue hardship as defined in this subsection ceases to exist, the property would become a countable asset.

(5) Verifications

(a) Fair Market Value and Equity Value

The fair market value and equity value of all countable real estate owned by the filing unit must be verified in accordance with 106 CMR 505.160(H)(2).

(b) Good Faith Effort to Sell Property

The applicant's or recipient's good faith effort to dispose of countable real property shall be verified in accordance with 106 CMR 505.160(H)(2).

Eligibility shall terminate if, at any time, the individual rejects a reasonable offer to buy the real estate. An offer to buy real estate is considered reasonable if it is at least two-thirds of the fair market value unless the individual proves otherwise.

(c) Dependency and Residence of Relative Living in the Former Home

1. The relationship shall be verified by birth certificates, marriage licenses, or any other documents necessary to establish relationship to the institutionalized individual.

2. Dependency shall be verified by a signed statement from the applicant or recipient's relative attesting to his or her dependency and the duration of the dependency on the institutionalized individual. The Department may require additional evidence if the relative's allegation of dependency is questionable or self-contradictory.

3. The verification of the relative's residence in the former home must be in accordance with 106 CMR 503.100(B).

(6) Lien

The Department will place a lien on real estate in accordance with 106 CMR 505.160(H)(3).

(J) Retroactive SSI and RSDI Benefit Payments

(1) Requirements

A retroactive SSI and/or RSDI benefit payment is noncountable in the month of receipt and for six months after the month of receipt.

Such payments must be deposited in a separately identifiable account. Any amount of the benefit payment still retained on the first day following the excluded periods described in 106 CMR 505.160(I)(1) shall become a countable asset.

(2) Verification

Verification of the amount of the benefit and the date of receipt is mandatory. The preferred source of verification is the notification letter from the Social Security Administration. The amount on deposit shall be verified by a bank book or bank statement that shows that the benefit payment is not commingled with other funds.

(K) Medicaid Qualifying Trusts

(1) Requirements

A Medicaid qualifying trust is a trust or similar legal device established other than by will by the applicant for or recipient of Medicaid or his or her spouse under which:

(a) The applicant or recipient is a beneficiary of all or part of the payments from the trust; and

(b) The distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the amount to be distributed to the applicant or recipient.

The amount deemed available to the applicant or recipient is the maximum amount of payments that the trustee has discretion to disburse to the applicant or recipient under the terms of the trust for the applicable budget period, except to the extent that such amount is considered temporarily inaccessible under the provisions of 106 CMR 505.150(A)(2)(b).

A trust will be deemed to be established by will to the extent the applicant or recipient demonstrates that the trust was funded by or through a will.

(2) Exception

A trust established prior to April 7, 1986, solely for the benefit of a resident of an intermediate care facility for the mentally retarded (ICF/MR) is excluded from the provisions of 106 CMR 505.160(K)(1)(a) and (b).

(3) Verifications

Verification must be a copy of the trust or similar legal document or a will, when appropriate, and information detailing investments and distributions made.

505.170: Noncountable Assets

Noncountable assets are those assets exempted from consideration when determining the total value of assets.

In addition to the noncountable assets listed in 106 CMR 505.150 and 505.160, the following assets are noncountable for purposes of Medical Assistance eligibility:

(A) The home of the filing unit and any land appertaining thereto, if located in Massachusetts and used as the principal place of residence. The Department will place a lien prior to the death of the recipient against any real estate in which the recipient has an ownership interest. This lien will be placed only if all of the conditions in 106 CMR 502.910 are met;

(B) The assets of any member of the household who is an AFDC, RRP, or SSI recipient;

(C) Household belongings such as furniture, appliances, decorations, linens, and cookware;

(D) Personal belongings, such as jewelry, books, and toys;

(E) Home produce grown or preserved by the filing unit;

(F) The value of food stamps;

(G) Lands held in trust for Native Americans as well as property purchased from payments made under Public Laws 92-254, 93-134, 94-540, and 94-114 or from the interest income from these payments;

(H) Stock held in a regional or village corporation for a native of Alaska pursuant to the Alaska Native Claims Settlement Act;

(I) Proceeds from any source reserved for the replacement or repair of an asset that is lost, damaged, or stolen and any interest earned on such proceeds, or the value of the in-kind replacement item. Such proceeds or in-kind replacements are excluded from assets for a period of nine months, beginning with the first day of the calendar month following the month of receipt. An additional nine-month extension may be granted when good cause exists;

(J) In an SSI-related filing unit, proceeds from the sale of a home used as the principal place of residence, provided the proceeds are used to purchase another home to be used as the principal place of residence. Such proceeds are excluded from countable assets for three months, beginning with the first day of the calendar month following the month of receipt. The Department will place a lien prior to the death of the recipient against any real estate in which the recipient has an ownership interest;

(K) Business and nonbusiness property essential to self-support; and property excluded under an SSA-approved plan for self-support;

(L) In an SSI-related filing unit, HUD settlement payments that can be verified as having been made under Section 236 of the National Housing Act provided these payments are conserved in a separate account;

(M) Any loan or grant including, but not limited to, scholarships the terms of which preclude its use for current maintenance;

(N) The total amount of any grant or loan to an undergraduate student for educational purposes made or insured under any program administered by the U.S. Commissioner of Education;

(O) The following funeral or burial arrangements for the applicant, recipient or his or her spouse:

(1) any burial space;

(2) one of the following:

(a) a separately identifiable amount not to exceed $1500 expressly reserved for funeral and burial expenses; or

(b) a life insurance policy designated exclusively for funeral and burial expenses with a face value of $1500 or less;

(3) the cash surrender value of burial insurance;

(4) prepaid irrevocable burial contracts; or irrevocable trust accounts designated for funeral and burial expenses.

Any burial space for any immediate family member is also non-countable.

Appreciated value or interest earned or accrued and left to accumulate on any contracts, accounts, or life insurance shall also be noncountable. Use of any of these assets including the interest accrued for other than funeral or burial arrangements of the applicant, recipient or his or her spouse shall make the asset available and countable under the appropriate provisions of 106 CMR 505.125 and 505.160.

The applicant, recipient or his or her spouse has the right to establish or change the designation of funds owned by him or her to any of the burial arrangements allowed in 106 CMR 505.170(0), (1), (2), (3) or (4).

If the allowed funeral and burial arrangement has been established within 30 days of the applicant's or recipient's being notified of his or her right to establish the arrangement, then it is deemed to be in existence on the first day of the third month prior to application.

(P) In an SSI-related filing unit, assistance received under the Disaster Relief Act of 1974 or other assistance provided under a federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States. Such assistance, and the interest earned on the assistance, shall be noncountable for nine months from the date of receipt. An additional nine-month extension may be granted when good cause exists;

(Q) In an SSI-related filing unit, the value of assistance to children under the National School Lunch Act;

(R) In an SSI-related filing unit, incentive allowances received under the Job Training Partnership Act;

(S) In an SSI-related filing unit, payments to volunteers under the Domestic Volunteer Service Act of 1973;

(T) In an SSI-related filing unit, the value of federally donated foods distributed pursuant to section 32 of Public Law 74-320 or section 416 of the Agriculture Acts of 1949;

(U) In an SSI-related filing unit, the value of assistance paid for a dwelling unit under the United States Housing Act of 1937, the National Housing Act, section 101 of the Housing and Urban Development Act of 1965, or Title V of the Housing Act of 1949;

(V) In an AFDC-related filing unit, earned income tax credits whether received as advance payments of earned income tax credits or as part or all of an income tax refund;

(W) Payments to eligible individuals of Japanese ancestry or their survivors under the Civil Liberties Act of 1988 and payments to eligible Aleuts (who were former residents of the Aleutian and Pribilof Islands) or their survivors under the Aleutian and Pribilof Islands Restitution Act, Public Law 100-383; and

(X) Agent Orange Settlement Fund payments made to Vietnam veterans or their survivors, in accordance with Public Law 101-201, effective January 1, 1989.

505.180: Institutionalized Spouse - Treatment of Married Couple's Assets

(A) Assessment

The Department must complete an assessment of the total value of a couple's combined countable assets and shall compute the spousal share as of the beginning of the first continuous period of institutionalization of one spouse that begins on or after September 30, 1989.

The Department may require payment of a fee for providing an assessment that is made not in conjunction with an application for Medicaid. The fee shall not exceed the reasonable expenses of providing and documenting the assessment.

When one spouse has entered a medical institution on or after September 30, 1989, and is expected to remain institutionalized over 30 days, either spouse may request the Department to make this assessment, even if the institutionalized spouse is not applying for Medical Assistance at that time.

The Department must give each spouse a copy of the assessment and the documentation used to make such assessment. Each spouse must be notified that he or she has the right to appeal the determination of countable assets and the community spouse's asset allowance when the institutionalized spouse (or representative) applies for Medical Assistance.

(1) Calculation of the Community Spouse's Share of the Couple's Total Combined Countable Assets

As of the beginning of the first continuous period of institutionalization beginning on or after September 30, 1989, the Department shall attribute an amount to the community spouse equal to one-half of a couple's combined countable assets but not exceeding $70,740. A community spouse's share, which is calculated as of the beginning of the first continuous period of institutionalization, beginning on or after September 30, 1989, remains a constant amount for purposes of determining the amount of assets that will be used to determine the institutionalized spouse's eligibility.

(2) Continuous Period of Institutionalization

A continuous period of institutionalization is at least 30 consecutive days of institutionalization in a medical institution or nursing facility. Continuity is broken by absences from institutions for at least 30 consecutive days.

(B) Determination of Eligibility for Institutionalized Spouse

At the time that the institutionalized spouse applies for Medical Assistance, the Department must:

(1) determine the couple's current total countable assets, regardless of the form of ownership;

(2) deduct the community spouse's asset allowance from the current combined total countable assets. The community spouse's asset allowance is not considered available to the institutionalized spouse when determining the institutionalized spouse's eligibility for Medical Assistance. The asset allowance is the greatest of the following amounts:

(a) the amount defined in 106 CMR 505.180(A)(1), provided it does not exceed $70,740;

(b) $14,148 if the total combined countable assets of the couple are between $14,148 and $28,296;

(c) the amount of the couple's total countable assets, if the combined total amount is $14,148 or less;

(d) a court-ordered amount; or

(e) an amount determined after a fair hearing; and

(3) compare the amount of the remaining assets to the Medical Assistance asset standard for one person, that is, $2,000. When the amount of the remaining assets is equal to or below $2,000, the institutionalized spouse has met the asset test of eligibility.

(C) Right to Appeal to Division of Hearings

(1) At the time the institutionalized spouse applies for Medical Assistance, either spouse may appeal the calculation of total countable assets and the calculation of the community spouse's share at 106 CMR 505.180(A), the attribution of assets at 106 CMR 505.180(B)(1), and the community spouse's asset allowance at 106 CMR 505.180(B)(2).

(2) If either spouse establishes at fair hearing that the amount of income generated by the community spouse's asset allowance at 106 CMR 505.180(B)(2) is inadequate to raise the community spouse's income to the minimum monthly spousal maintenance needs allowance at 106 CMR 506.220(B)(1), the Division of Hearings shall increase the community spouse's asset allowance by an amount adequate to provide the minimum monthly spousal maintenance needs allowance.

(D) Post-Eligibility Transfer of Assets

After the institutionalized spouse has been determined eligible for Medical Assistance, the institutionalized spouse's assets that are considered part of the community spouse's asset allowance must be transferred to the community spouse. Assets must be made available to meet the needs of the community spouse if they are to be excluded in determining the continuing eligibility of the institutionalized spouse. Therefore, they must be transferred to the community spouse or to a third party for the sole benefit of the community spouse.

This transfer must be performed as soon as practicable but no later than 90 days immediately following the eligibility determination. During this 90 day period the rules in Section 505.120 do not apply to assets transferred to the community spouse.

The transfer must be made within 90 days after the eligibility date unless there is court involvement in assigning couples' property through support actions or a Division of Hearings appeal. Additional time may be granted beyond the 90 day period if needed to secure appointment of a guardian or conservator to make the transfer on behalf of an incompetent institutionalized spouse.

The amount of the assets transferred when added to the assets owned by the community spouse, cannot exceed the amount defined in Subsection 505.180(B)(2).

After the protected period is over, all assets that remain in the institutionalized spouse's name shall be counted in determining his or her eligibility.

(E) Retroactive Eligibility

To determine the earliest possible date of eligibility of the institutionalized spouse for the three month retroactive period prior to application in a continuous period of institutionalization, the Department will deduct the amount defined in Subsection 505.180(B)(2) from the couple's total countable assets.

(F) Eligibility for Community Spouses

The amount defined in Subsection 505.180(B)(2) must be counted in determining the community spouse's eligibility for Medical Assistance.

505.200: Income

Income is all monies received by the filing unit including recurrent payments, payments in kind, or lump sum payments.

Countable income is all monies, earned or unearned, that are included for eligibility determination.

Noncountable income is all monies that are exempt from inclusion.

All income of all members of the filing unit shall be countable unless exempted herein.

505.205: Attribution of Income for an Institutionalized Member of a Couple

(A) Non-Trust Property

The following criteria is used to establish ownership in non-trust property.

(1) If payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(2) If payment of income is made in the name of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(3) If payment of income is made in the name of the institutionalized spouse and the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(B) Trust Property

In the case of a trust, income shall be considered available to each spouse as provided in the trust, or in the absence of a specific provision in the trust the following criteria is used.

(1) If payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(2) If payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(3) If payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(C) Property with No Instrument

In the case of income not from a trust in which there is no instrument establishing ownership, subject to Subsection 505.205(D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

(D) Rebutting Ownership

The rules of Subsection 505.205(A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under Subsection 505.205(A) and (C).

505.210: Countable Earned Income

Earned income is compensation received for work or services performed. With respect to self-employment, earned income is gross proceeds less the cost of doing business.

(A) Income from Employment

(1) Requirements

All income from employment including wages, salaries, tips, fees, commissions, severance pay, or other compensation, such as income-in-kind, is countable unless specifically excluded.

(2) Verifications

The verification of income from employment is mandatory at application or redetermination and when a change in income is reported, and shall be one of the following:

a. a written statement signed by an employer;
b. pay envelopes; or
c. pay stubs.

Documentation shall be current and shall include income information from the four (4) consecutive weeks prior to the application or redetermination date. The verification must show the gross wages, deductions and number of hours worked if needed to verify child care or underemployment.

(B) Income from Self-Employment

(1) Requirements

A person who directly controls the goods produced or services provided, the work undertaken, and the fees and charges assessed is self-employed.

Earned income from self-employment is the gross proceeds minus the cost of doing business. The cost of doing business includes all costs necessary to maintain the business. Personal expenses, such as lunches and transportation to and from work, are not included.

(2) Verifications

a. Verification of gross proceeds for the twelve most recent months is mandatory and shall be one or more of the following:

1. tax returns;
2. bank statements;
3. accounting records, certified and signed by a public accountant; or
4. other appropriate documents.

b. The verification of each business expense claimed is mandatory and shall be as many of the following as necessary:

1. records of wages paid to the employee;
2. rent receipts;
3. utility receipts;
4. receipts for purchase of inventory;
5. property taxes; or
6. other appropriate documents.

(C) Income from Real Estate

(1) Requirements

Rental income is income from rented property owned by a member of the filing unit. This income is countable and

may be earned or unearned. The income is considered earned only if such rental income is received in the course of a trade or business as a real estate dealer.

A real estate dealer is one engaged in the business of selling real estate to customers for profit. One who holds real estate for investment or speculation, and receives rental income, is not a real estate dealer.

Business expenses which may be allowed include carrying charges, costs of fuel and utilities provided to tenants, and any maintenance and repair costs.

If the individual occupies an apartment in the same building from which he receives rental income, carrying charges are prorated per unit. The cost of fuel and utilities are prorated if they are paid through a single heating unit or meter.

Actual maintenance and repair costs, other than cosmetic changes, may be deducted from the amount of rental income if the individual verifies such expense.

(2) Verifications

a. The verification of rental income is mandatory and shall be one of the following:

1. tax records;
2. leases; or
3. rental agency documents

b. The verification of any claimed business expenses is mandatory and shall be one of the following for the most recent twelve months:

1. current tax bill less abatement;
2. records of betterment taxes;
3. lender documents showing interest and principal payments on the mortgage;
4. records of insurance premiums;
5. utility bills;
6. refuse collection bills;
7. necessary repair bills (for non-cosmetic purposes); or
8. other appropriate documents.

(D) Income from Roomers and Boarders

(1) Requirements

Payment for room and/or meals received from anyone other than a member of the filing unit or a child of the grantee-relative is countable earned income. Income from roomers and boarders is the amount received from the roomer or boarder, less a standard deduction allowed for business expenses. When the income is for the rental of a room only, the business expense allowed is 25 percent of the income. When the income is for both a room and meals, the business expense allowed is 75 percent of the income. Actual expenses are allowed only if the provider can document that they exceed these standard deductions.

(2) Verifications

The verification of countable income from roomers and boarders is mandatory and shall be one of the following:

a. a copy of the written agreement signed by both parties indicating the amount and frequency of payment; or

b. a signed statement from the person making the payment indicating the amount and frequency of payment.

If the applicant or recipient claims that actual expenses exceed the standard deduction, verification shall consist of receipts documenting actual expenses.

505.220: Countable Unearned Income

Income that does not directly result from an individual's own labor or services is unearned. Unless specifically excluded by 106 CMR 505.230, unearned income, including the following, is countable:

(A) Income from Benefit Payments

(1) Requirements

All recurring income received from public or private organizations for purposes of personal maintenance shall be countable, including, but not limited to, Social Security benefits, pensions and annuities, Veterans' benefits, state veterans' benefits in AFDC-related cases only, Railroad Retirement, Black Lung benefits, Brown Lung benefits, Workers' Compensation and Unemployment Compensation Insurance benefits, Armed Forces benefits and strikers' benefits.

(2) Verification

Income from benefit payments shall be verified by one of the following:

a. a copy of the benefit or award letter;

b. retirement fund documents indicating the amount and frequency of the benefits;

c. social security benefit statements;

d. a written statement from the agency or organization making the payment that indicates the amount and frequency of the benefit payment;

e. a copy of the benefit payment check; or

f. information received by the Department through a computer match from agencies such as the Social Security Administration (SSA) or the Department of Employment and Training (DET) that indicates the current amount and frequency of the payment.

(B) Contribution and Support Payments

(1) Requirements

Regular contributions from friends and relatives are countable income except as specified in 106 CMR 505.230: Noncountable Income. Alimony and child support from legally responsible relatives are countable income.

The first $50 of a current monthly support payment received by an AFDC-related assistance unit is disregarded. Two-thirds of a child support payment paid on behalf of an SSI-related child is countable income.

(2) Verifications

The verification of the amount and frequency of contributions and support payments is mandatory. The preferred sources of verification are:

a. the court payment record; or

b. copies of the cancelled checks or money orders.

(C) Income from Investments, Royalties, and Annuities

(1) Requirements

Income from royalties, annuity payments and investment income, such as dividends and interest, are countable.

(2) Verifications

The verification of investment income and income from royalties and annuities is mandatory and shall be a statement from a financial institution, broker, investment firm, company or source of the royalty indicating the amount of interest, dividends, royalties paid, or annuity payments, frequency of payment, and the amount paid in the year to date.

(D) Income-In-Kind

Income-in-kind is income other than cash provided to members of the filing unit. It may consist of free rent, free utilities, clothing, or food, but it is not necessarily limited to these. Income-in-kind may be earned or unearned.

(1) Requirements

Income-in-kind is countable. Its value shall be determined from the following table when applicable. The value of income-in-kind not listed below shall be the fair market value of goods or services received.

TABLE OF VALUES FOR INCOME-IN-KIND

INCOME-IN-KIND	VALUE	
Shelter: Unheated Facility	$102.00	per month per household
Shelter: Heated Facility	$126.30	per month per household
Fuel	$ 27.90	per month per household
Utilities	$ 18.60	per month per household
Food	$ 41.80	per month per individual

(2) Verifications

The verification of the value of income-in-kind, not listed above, is mandatory and shall be one of the following:

a. a written statement from the person contributing the goods or services; or

b. receipts verifying the actual value of in-kind income.

(E) Income from Real Estate (Unearned)

(1) Requirements

Rental income is income from a rented house or apartment owned by a member of the MA filing unit. This income is countable and may be earned or unearned. Income is considered unearned if the individual is not in the trade or business as a real estate dealer.

A real estate dealer is one engaged in the business of selling real estate to customers for profit. One who holds real estate for investment or speculation, and receives rental income, is not a real estate dealer.

Business expenses which may be allowed include carrying charges, costs of fuel and utilities provided to tenants, maintenance and repair costs, and fees paid to a rental agent, resident manager or other person or agency.

If the individual occupies an apartment in the same building from which he receives rental income, carrying charges are prorated per unit. The cost of fuel and utilities are prorated equally if they are paid through a single heating unit or mater.

Actual maintenance and repair costs, other than cosmetic changes, may be deducted from the amount of rental income received if the individual verifies such expenses.

(2) Verifications

Verifications of rental income and business expenses are mandatory. The preferred source of verification of income is one of the following:

a. tax records;

b. leases; or

c. rental agency documents.

The preferred source of verification of business expenses is any of the following, where applicable:

1. current tax bill showing abatement, if any;

2. contract with a rental agency, resident manager or other person or agency showing management fee paid;

3. records of betterment tax bills;

4. lender documents showing interest and principal payments on the mortgage;

5. records of insurance premiums;

6. utility bills;

7. refuse collection bills; or

8. necessary repair bills (for non-cosmetic purposes).

Unless the individual can demonstrate that the previous year's income and business expenses are unrepresentative of future income and business expenses, both income and expenses must be verified for the preceding 12 months.

(F) Lump Sum Payments

(1) Requirements

A lump sum payment is a one time only payment that represents either windfall payments such as inheritances or legacies; or the accumulation of recurring income such as retroactive Unemployment Compensation, Railroad Retirement, Federal VA benefits or Social Security (RSDI).

Lump sum payments are counted as unearned income in the calendar month received and as an asset in subsequent months except in the situations specified below:

a. subject to the provisions of 505.160(I), a retroactive RSDI and/or SSI benefit payment is not counted as income or an asset for:

1. nine months after the month of receipt if received between October 1, 1987 and September 30, 1989; or

2. six months after the month of receipt if received on or after October 1, 1989.

b. proceeds reserved for the replacement or repair of an asset that is lost, damaged or stolen and any interest earned on such proceeds subject to the provisions of subsection 505.170(I);

c. proceeds from the sale of a home used as the principal place of residence subject to the provisions of subsection 505.170(J);

d. proceeds from the sale of real estate other than a home subject to the provisions of subsection 505.160(H);

e. proceeds from the sale of nonexempt vehicles subject to the provisions of subsection 505.160(G).

(2) Verifications

Verification of a lump sum payment is mandatory and shall be verified when received by one of the following:

a. a benefit or settlement award letter;

b. a retirement fund document indicating the amount of the lump sum payment;

c. a written statement from the agency, company or institution making the payment; or

d. a copy of the payment document.

(G) Life Insurance Proceeds

(1) Requirements

Life insurance proceeds are proceeds received by the beneficiary of a life insurance policy as a result of the death of the insured. The countable portion of these proceeds is considered income in the month received and is an asset in subsequent months.

a. AFDC-Related Filing Units

The total amount of life insurance proceeds is countable income.

b. SSI-Related Filing Units

The amount of life insurance proceeds that exceeds either $1,500 or the amount expended by the beneficiary of the policy on the cost of the insured individual's last illness and burial, whichever is less, is countable income.

(2) Verifications

Verification of both the life insurance proceeds and medical and burial expenses shall be mandatory.

a. The mandatory verification of life insurance proceeds shall be a statement from the insurance carrier or agent.

b. The mandatory verification of the medical and burial expenses shall be the following:

1. hospital records and/or doctors' bills; and

2. funeral home receipts, and/or cemetery or interment bills.

505.230: Noncountable Income

Noncountable income is all monies exempted from consideration in the determination of total income. The following are noncountable for purposes of Medical Assistance eligibility:

(A) the income of any member of the filing unit who is an AFDC, RRP, GR, Pickle or SSI recipient;

(B) income received on an irregular or infrequent basis and totaling less than $30 per quarter for an AFDC-Related filing unit member, and less than $20 unearned or $10 earned per month for SSI-Related cases;

(C) $30 and/or one-third of countable earned income subject to the provisions of Section 506.120;

(D) payments under the Nutrition Program for the Elderly (Title VII of the Older American Act of 1965);

(E) Social Security (RSDI) benefits paid to persons 18 through 21 years of age who are full-time students, in an AFDC-Related filing unit;

(F) The first $1,200 of quarterly earned income, not to exceed $1,620 in a calendar year, of a student 21 years of age and under who is not married or the head of a household, in an SSI-Related filing unit;

(G) Expense allowances and weekly incentive payments of up to $30 from the Division of Employment Security;

(H) Incentive payments of $30 per week or less received under a vocational rehabilitation program of the Massachusetts Rehabilitation Commission;

(I) The tuition and fee portions of grants, scholarships, fellowships, and other student aid payments;

(J) The total amount of any grant or loan to an undergraduate student for educational purposes made or insured under any program administered by the U.S. Commissioner of Education;

(K) Payments or reimbursements to volunteers serving as foster grandparents, senior health aides, senior companions, or serving in the Service Corps of Retired Executives, or in VISTA (for AFDC-Related cases only), or in any other program established under the Domestic Service Act of 1973, provided the volunteer was a a recipient of public assistance upon entering the volunteer program;

(L) Funds distributed to, or held in trust for, members of any Indian tribe pursuant to a judgment of the Indian Claims Commission of the Court of Claims;

(M) The tax-exempt portions of payments made under the Alaska Native Claims Settlement Act;

(N) Payments to Native Americans under Public Law 92-254, 93-134, 94-540 and 94-114 including interest income from these payments. Property purchased with these funds is a non-countable asset (see Section 505.170);

(O) Housing subsidies received under any Massachusetts or federal housing program;

(P) Experimental Housing Allowance Program payments made under contracts entered into prior to 1975;

(Q) Relocation payments made by federal, state, or other agencies completing public projects with federal or state assistance;

(R) Disaster Relief Assistance payments;

(S) Payments for the foster care of a child if the child was placed in the applicant's or recipient's home by a public or private nonprofit child placement or child care agency;

(T) Payments for a room and/or meals from a child of the grantee relative in an AFDC-Related filing unit;

(U) The total amount of Social Security cost-of-living increases pursuant to Section 504.540;

(V) Earned or unearned income needed to fulfill an SSA-approved self-support plan, for an SSI-Related individual;

(W) One-third (1/3) of a child support payment received by an SSI-Related child from an absent parent;

(X) The value of Food Stamps;

(Y) The value of assistance received under the Child Nutrition Act of 1966 and the National School Lunch Act;

(Z) Work study income of undergraduate students in AFDC-Related filing units;

(AA) The first fifty dollars ($50) of a current monthly support payment received by an AFDC-related assistance unit pursuant to Section 505.220 (B)(1);

(BB) In AFDC-Related filing units earnings of a child(ren);

(1) all earned income of a child(ren) under age fourteen (14);

(2) all earned income of a child(ren) age fourteen (14) or older who is a full-time student or a part-time student who is a part-time employee;

(3) for a period of six (6) consecutive months in a calendar year, all earned income of a child(ren) who is not a student or is a part-time student and a full-time employee whose earned income is received from participation in a Job Training Partnership Act (JTPA) program.

(CC) Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become a part of the separately identifiable burial fund;

(DD) For AFDC-Related filing units, cash contributions from a nonlegally responsible person(s) that:

(1) are restricted for a specific purpose; and

(2) provide for a portion of the needs specified in 106 CMR 505.220(D): Income-In-Kind or provide for needs not included in 106 CMR 505.220(D).

A contribution from a nonlegally responsible person(s) that meets the entire cost of one or more of the needs specified in 106 CMR 505.220(D): Income-In-Kind is countable income, and is deducted using the standard values in 106 CMR 505.220(D);

(EE) Payments from the Home Energy Assistance Program;

(FF) For AFDC-related filing units, assistance from other social service agencies or organizations that does not duplicate assistance received under AFDC;

(GG) For AFDC-related filing units, AFDC payments resulting from a correction of an underpayment or a fair hearing decision;

(HH) For AFDC-related filing units, refunds from a utility company, landlord, or other vendor that were originally from AFDC benefits, fuel assistance, or other noncountable income funds;

(II) For AFDC-related filing units, all earned income tax credits whether received as advance payments of earned income tax credits or as part or all of an income tax refund;

(JJ) In an SSI-related filing unit, assistance received under the Disaster Relief Act of 1974 or other assistance provided under a federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States. Such assistance, and the interest earned on the assistance, shall be noncountable for nine months from the date of receipt. An additional nine-month extension may be granted when good cause exists;

(KK) In an SSI-related filing unit, the value of assistance to children under the National School Lunch Act;

(LL) In an SSI-related filing unit, incentive allowances received under the Job Training Partnership Act;

(MM) In an SSI-related filing unit, payments to volunteers under the Domestic Volunteer Service Act of 1973;

(NN) In an SSI-related filing unit, the value of federally donated foods distributed pursuant to section 32 of Public Law 74-320 or section 416 of the Agriculture Acts of 1949;

(OO) In an SSI-related filing unit, the value of assistance paid for a dwelling unit under the United States Housing Act of 1937, the National Housing Act, section 101 of the Housing and Urban Development Act of 1965, or Title V of the Housing Act of 1949;

(PP) Payments to eligible individuals of Japanese ancestry or their survivors under the Civil Liberties Act of 1988 and payments to eligible Aleuts (who were former residents of the Aleutian and Pribilof Islands) or their survivors under the Aleutian and Pribilof Islands Restitution Act, Public Law 100-383;

(QQ) Agent Orange Settlement Fund payments made to Vietnam veterans or their survivors, in accordance with Public Law 101-201, effective January 1, 1989;

(RR) Money received from a loan secured by the equity in the home of an individual who is aged 60 or over (so-called "reverse mortgage");

(SS) In an SSI-related filing unit, reparation payments from the Federal Republic of Germany.

505.300: The Budget Period

The budget period is a six (6) month prospective period which starts on the first day of the month of application on which the applicant would have been eligible, or on the date of service of the first bill which the recipient wishes to have covered by MA. This date must not be earlier than three (3) months prior to the month of application.

505.310: Adjustments to the Budget Period

Income determination for prospective eligibility in cases involving self-employment, irregular income, and reduction or termination of employment shall be as follows:

(A) self-employment income is averaged for the 12-month period preceding the date of application or redetermination;

(B) seasonal employment income is based on actual earnings in the most recent earning season;

(C) irregular actual income is averaged over a period of 3 months;

(D) reduced or terminated employment income is based on the anticipated termination date as verified in writing by the employer.

505.320: Conversions to Monthly Amounts

Income which is received on other than a monthly basis shall be converted to a monthly amount before being used in eligibility calculations, as follows:

(A) if the employee is paid weekly, the average of the last four weeks' pay shall be multiplied by 4 1/3 or 4.333 to obtain an anticipated monthly wage. If the applicant or recipient has worked less than four weeks, the wage information available shall be used initially and the figure revised, if necessary, when four weeks' wage information is available.

(B) if the employee is paid bi-weekly, an average of the last two consecutive pay periods shall be multiplied by 2 1/6 or 2.167 to obtain a monthly figure. If the employee is paid twice a month, the last two consecutive pay periods shall be added to obtain a monthly figure.

(C) If the employee in either of the cases above has some payroll deductions which are made on other than a weekly, bi-weekly or semi-monthly basis (e.g. monthly), these may be verified by means of any pay stub from the past four weeks which lists the deductions or by a letter from the employer. Such deductions must be converted to monthly amounts and must be included in determination of the employee's work-related expenses.

If the applicant or recipient has worked less than four weeks, the wage information available shall be used initially and the figure revised, if necessary, when two consecutive pay periods wage information is available.

(D) If the employee is paid monthly the monthly figure shall be used.

(E) If the employee receives a contractual annual salary, the amount to be used is the contractual annual salary divided by 12. Verification of the annual salary should be obtained in the form of a copy of the contract or a letter stating the annual salary to be received.

(F) Pay stubs or a statement showing wages paid in the year-to-date may be used to determine an anticipated monthly wage provided the number of weeks' pay represented is shown or can be computed. The average weekly earnings derived are multiplied by 4 1/3 or 4.333 to obtain a monthly figure.

505.400: Financial Responsibility

Certain individuals have the option of being included in the assistance unit. If they so choose, they must also be included in the filing unit. Other individuals are ineligible for consideration in the assistance unit yet have financial responsibility for those in the assistance unit and must therefore be included in the filing unit.

The assets and income of all members of the filing unit shall be considered when determining eligibility.

505.410: Natural and Adoptive Parent(s)

(A) Financial Responsibility

A parent, whether natural or adoptive, has the financial responsibility for the support of his or her children under age 18.

(1) Children Residing with Parent(s)

When a child under age 18 resides with a parent, the assets and income of the parent are considered available whether or not actually contributed to the child, unless the child meets the criteria described in 106 CMR 504.160(A)(1).

(2) Children Residing Apart from Parent(s)

When a parent and a child under age 18 do not reside together, the parent is financially responsible for the child, but only those assets and income actually contributed by the parent(s) are considered in determining eligibility of the child(ren).

(3) Children in Long-Term-Care Facilities

When a child under age 18 resides in a long-term-care facility, the income and assets of the parent are considered available through the end of the calendar month of separation.

(4) SSI-Related Child in an Acute Hospital

When an SSI-related child under age 18 who is absent from the parental home and is not expected to return to the parental home by the end of the calendar month of separation or the month immediately following is an applicant or recipient of Medicaid, the assets and income of the parents are not considered available to the child. For newborns who have never resided with their parents, the date of birth is considered the date of separation.

(B) Inclusion in the Assistance Unit

When dependent children reside with a parent, the parent is included in the assistance unit in the MA-AFDC Program.

A caretaker relative other than the parent may also be included in the assistance unit if he or she meets the requirements of 106 CMR 504.170.

506.420: Long-Term-Care Cases

The MA Income Standard for an AFDC-Related or SSI-Related long-term-care case is $60.00 per month.

506.430: Federal-Poverty-Level Income Standards

(A) The federal-poverty-level income standards are used to determine the financial eligibility of the following person(s):

(1) those aged and disabled persons who meet the basic, categorical, and asset requirements for MA; and

(2) qualified Medicare beneficiaries who meet the basic MA requirements and QMB asset requirements described in 106 CMR 507.500.

(B) Eligibility of children aged one, two, three, four, and five is based on 133% of the federal-poverty-level income standards.

(C) Eligibility of the following persons is based on 185% of the federal-poverty-level income standards:

(1) a pregnant woman and her unborn child(ren); and

(2) a child(ren) under age one.

The spenddown policy described in 106 CMR 506.500 et seq. does not apply when using these income standards.

FEDERAL-POVERTY-LEVEL INCOME STANDARDS
COMMUNITY CASES

Number of Persons	Income Standard
1	$ 552
2	740
3	929
4	1117
5	1305
6	1494
7	1682
8	1870
Each Additional Person	189

506.440: SSI Payment Standards

MASSACHUSETTS SSI PAYMENT STANDARDS

CATEGORY	LIVING ARRANGEMENT			
	A	B	C	E
	FULL COST LIVING EXPENSES	SHARED LIVING EXPENSES	HOUSEHOLD OF ANOTHER	DOMICILIARY CARE (LICENSED R.H.)
Individual				
Aged	$ 562.82	$ 473.26	$ 393.70	$ 727.00
Disabled	548.39	464.40	376.92	727.00
Blind	583.74	583.74	583.74	583.74
Member of a Couple				
Aged	$ 426.86	$ 426.86	$ 325.24	$ 727.75
Disabled	416.03	416.03	314.43	727.75
Blind	583.74	583.74	583.74	583.74

NOTE: The personal care allowance in licensed rest homes is $60.
The personal care allowance in long-term-care facilities is $65.

(a) Case Management Services;

(b) Homemaker Services;

(c) Chore Services;

(d) Social Day Care; and

(e) Respite Care Services; and

4. must be otherwise eligible for MA.

b. When an applicant is receiving hospice care, as described in 106 CMR 507.400, only the assets and income of the applicant or recipient are considered in determining his or her eligibility for MA.

When determining the eligibility of the spouse of the applicant or recipient, described in 106 CMR 505.450(A)(1)a. or b., the assets and income of both spouses are considered mutually available whether or not actually contributed (unless both spouses meet the conditions of 106 CMR 505.450(A)(1)a. or b.).

(2) Spouses Residing Apart

a. AFDC-Related Filing Unit

When the deprivation factor is continued absence, the income and assets are considered available only for the days actually lived together (with the exception of court-ordered payments and certain legal and contractual arrangements).

If only one spouse is an applicant for or recipient of Medical Assistance, and they do not reside together because the spouse entered a long-term-care facility or nursing facility before 9/30/89 and continues to reside in the long-term-care facility or nursing facility or entered a medical facility before 9/30/89 and has remained continuously in the medical facility and is now on Administrative Days, their assets are considered mutually available through the end of the calendar month of separation.

If only one spouse is an applicant for or recipient of Medical Assistance, and they are residing apart because one spouse entered a medical institution on or after 9/30/89 and is expected to reside there for more than 30 days, they are subject to the provisions of 106 CMR 505.180 and 506.220(B). In no event will the income of the community spouse be used to determine eligibility for the institutionalized spouse.

b. SSI-Related Filing Unit

If both spouses are applicants for or recipients of Medical Assistance and do not reside together for reasons other than admission to a medical institution, their assets and income are considered mutually available for the calendar month of separation.

If only one spouse is an applicant for or recipient of Medical Assistance, and they do not reside together because the spouse entered a long-term-care facility before 9/30/89 and continues to reside in the long-term-care facility, or entered a medical facility before 9/30/89 and has remained continuously in the medical facility and is now on Administrative Days, their assets are considered mutually available through the end of the calendar month of separation.

If only one spouse is an applicant for or recipient of Medical Assistance, and they are residing apart because one spouse entered a medical institution on or after 9/30/89 and is expected to reside there for more than 30 days, eligibility is determined in accordance with the provisions of 106 CMR 505.180 and 506.220(B). In no event will the income of the community spouse be used to determine eligibility for the institutionalized spouse.

(B) Inclusion in the Assistance Unit

The spouse of a recipient of Medical Assistance may be included in the assistance unit only if all applicable basic, categorical, and financial requirements are met.

505.460: Selection of the Assistance Unit

Under certain circumstances, an individual or family may be considered for eligibility in more than one assistance unit or category of assistance (e.g., AFDC-Related Medicaid, SSI-Related Medicaid, and/or QMB).

The individual or family may select the composition and categorical relatedness of the assistance unit for which he or she wants to be considered, and the worker shall explain the options available to him or her.

Assets and income shall be considered in accordance with the regulations for financial responsibility in 106 CMR 505.400 through 505.450, appropriate to the composition and categorical relatedness of the assistance unit selected.

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506.000: Overview of Calculation of Financial Eligibility

Financial eligibility is determined by comparing the net countable income and assets available to persons in the filing unit with the asset limitation and income standards established by the Department. In determining the eligibility of a pregnant woman, the size of the filing unit will be determined as if the child(ren) were born and living with the family.

506.100: Income Deductions: Community Cases

The following income deductions are allowed for community cases: unearned, earned, and general.

506.110: Unearned Income Deductions: Community Cases

SSI-Related community cases are allowed an unearned income deduction of $20 per individual or married couple. In filing units with a disabled child(ren), income deemed to each disabled child(ren) is also subject to a $20 disregard.

If total unearned income of an individual or couple residing in the community is less than $20, any remaining portion of this deduction shall be applied to earned income. If there is no unearned income, the entire $20 shall be deducted from earned income, in accordance with 106 CMR 506.120.

The first $50 of a current monthly support payment received by an AFDC-related filing unit is disregarded.

506.120: Earned Income Deductions: Community Cases

(A) AFDC-Related Filing Units

(1) Work-Related Expenses

a. In AFDC-related community cases, each employed member of the filing unit is entitled to a work-related expense deduction of $90 monthly from gross wages.

b. Restrictions

This deduction does not apply to the earned income of a member of the filing unit for the month in which one of the following conditions exist: (1) The member of the filing unit has reduced his income, terminated his employment or refused a bona fide job offer without good cause; or (2) the member of the filing unit has failed without good cause to make a timely report of income received. Good cause for failure to make a timely report of a change of circumstances shall be limited to demonstrated serious illness.

The work-related expense deduction shall not be applied to rental, roomer, or boarder income.

(2) Eligibility for the $30 and One-third Disregard and the $30 Disregard

A family or an individual who has received AFDC cash assistance in any one of the four calendar months that precedes the month of application for Medical Assistance is eligible to have $30 and one-third of remaining gross earned income, after work-related expense deductions, disregarded. A family or an individual who has received AFDC cash assistance in any one of the five to 12 calendar months that precedes the month of application for Medical Assistance is eligible to have $30 disregarded from earned income.

The $30 and one-third disregard continues to be applied only as long as it can be established that in at least one of the preceding four calendar months AFDC cash assistance was received. The $30 disregard continues to be applied only as long as it can be established that in at least one of the preceding 12 months AFDC was received.

The $30 and one-third disregard and the $30 disregard of earned income does not apply in the month in which the individual:

a. terminated his employment or reduced his income without good cause; or

b. refused without good cause an offer of employment through the Department of Employment and Training or any other bona fide offer of employment by an employer. Determination as to whether an offer was a bona fide offer of employment is to be made by the Department.

(3) Dependent-Care Deduction

a. In each AFDC-related community case, there shall be allowed a deduction from income for the care of a dependent child or an incapacitated individual requiring such care. If the applicant or recipient is eligible for the $30 and one-third disregard, the dependent care deduction shall be made after the $30 and one-third or $30 has been deducted.

The amount allowed as a deduction shall be the actual cost of dependent care, including the cost of transporting dependents to and from dependent care, subject to the following maximums.

A filing unit member who is employed less than full-time may receive a proportionate share of the maximum allowable deduction. The following standards shall be used to determine the maximum proportionate share of the applicable deduction, per dependent child or incapacitated individual, to which an individual is entitled. In all situations, the amount allowed for the dependent care deduction shall be the actual expenditure for dependent care, including the cost of transporting dependents to and from dependent care, or the maximum allowable deduction, whichever is less.

		MAXIMUM DEDUCTIONS	
WEEKLY HOURS	MONTHLY HOURS	DEPENDENT TWO OR OVER	CHILD UNDER TWO
1 - 10	1 - 43	$44	$50
11 - 20	44 - 87	$88	$100
21 - 30	88 - 130	$132	$150
31 - above	131 - above	$175	$200

b. Restriction

A member of the filing unit who meets the provisions of Subsection (A)(1)b shall not be eligible for the dependent care deduction.

c. Verification

The expenses for which the dependent care deduction is claimed shall be verified as follows:

1. the only acceptable verifications for dependent care expenses are:

   (a) a signed and dated statement from the dependent care provider; and/or

   (b) a cancelled check or money order payable to the dependent care provider.

   If none of the above documents is available, verification of dependent care expenses shall be a signed and dated statement from the recipient of the actual cost of dependent care.

2. The verification of the cost of transporting dependents to and from dependent care shall be a signed and dated statement from the recipient of the actual cost of such transportation.

3. The incapacity of an individual in the assistance unit other than a dependent child for whom dependent care costs are being claimed must be verified. Incapacity is verified by a current statement from a competent medical authority, as defined in 106 CMR 501.500(H).

(B) SSI-Related Filing Units

A standard earned income deduction is allowed to SSI-Related filing units. The standard earned income deduction is deducted from the gross earned income of each employed individual or married couple in the filing unit.

The following amounts shall be deducted from gross earned income in the order indicated:

(1) $20, if there is no unearned income in the filing unit, or, if there is unearned income of less than $20, then the balance of the $20 is disregarded from earned income;

(2) the next $65 a month of earned income;

(3) one-half of the remaining earned income.

506.130: General Income Deductions: Community Cases

General income deductions are made from countable income after all other unearned and earned deductions have been allowed. In AFDC-Related filing units, a deduction for court-ordered payments for the support of dependents and a deduction for health-care coverage (when deducted from pay) shall be allowed.

(A) Deductions for Health-Care Coverage

(1) Requirements

When health insurance premiums or membership costs in a health maintenance organization are deducted from the earnings of an AFDC-Related filing unit member, the individual shall be entitled to an earned income disregard of that amount. This disregard shall be in addition to the $90 work-related expense deduction allowed in 106 CMR 506.120(A)(1).

When payments are made directly to a health maintenance organization or to an insurer, such payments shall be considered in meeting the spenddown liability.

(2) Verifications

The verification of proof that a deduction from pay was made is mandatory and shall be a pay stub or letter from an employer specifying the amount deducted.

(B) Deductions for Court-Ordered Payments and CSEU Agreements

(1) Requirements

In AFDC-Related filing units, payments, such as child support and alimony, made by an applicant or recipient pursuant to a court's order for the support of dependents, are deducted from income. Payments made pursuant to an agreement with a Child Support Enforcement Unit shall also be deductible.

(2) Verifications

The mandatory verification of such court ordered payments shall be one of the following:

a. a copy of the court order and a record of payment; or

b. a written statement from an employer documenting the execution of a wage assignment.

506.200: Income Deductions: Long-Term-Care Cases

Earned and general income deductions are allowed for long-term-care cases.

506.210: Earned Income Deductions: Long-Term-Care Cases

In AFDC-related long-term-care cases, each member of the filing unit who is employed full or part-time, is entitled to a maximum work-related expense deduction of $90 in accordance with the provisions of Subsection 506.120(A)(1).

SSI-related long-term-care cases are allowed the following earned income deductions for each member of the filing unit in a long-term-care facility:

(A) $11; and

(B) Any of the following work-related expenses deducted from salary:

(1) Social Security taxes (FICA);
(2) federal and state income taxes;
(3) retirement and employee benefit plans;
(4) health or medical insurance premiums; and
(5) union dues.

506.210: Earned Income Deductions: Long-Term-Care Cases

In AFDC-related long-term-care cases, each member of the filing unit who is employed full or part-time, is entitled to a maximum work-related expense deduction of $75 in accordance with the provisions of Section 506.120(A)(1).

SSI-related long-term-care cases are allowed the following earned income deductions for each member of the filing unit in a long-term-care facility:

(A) $11; and

(B) Any of the following work-related expenses deducted from salary:

(1) Social Security taxes (FICA);
(2) federal and state income taxes;
(3) retirement and employee benefit plans;
(4) health or medical insurance premiums; and
(5) union dues.

506.220: General Income Deductions: Long-Term-Care Cases

General income deductions must be taken in the following order for: (a) personal needs allowance; (b) maintenance of a spouse and/or dependent children; (c) maintenance of a former home; and (d) health care coverage and incurred expenses.

(A) Personal Needs Allowance

A deduction shall be made for a long-term-care applicant's or recipient's personal needs allowance. This amount shall be the Department's current institutional income standard for one person as specified in Section 506.420.

If the applicant or recipient does not have income totaling the standard, the Department will pay the applicant or recipient an amount up to that standard on a monthly basis.

(B) Deductions for Support of a Spouse and/or Dependent Children

(1) Requirements

When an applicant or recipient in long-term care has a spouse and/or dependent child(ren) at home, a deduction for their support is allowed if:

a. the countable assets of the family members remaining in the community are within the asset limitations for a family of that size; and

b. the net income of the family members remaining in the community, computed according to the standards of this chapter, is less than the MA Income Standard for a family of that size.

506.220: General Income Deductions: Long-Term-Care Cases

General income deductions must be taken in the following order: (a) a personal needs allowance; (b) a spousal maintenance needs allowance; (c) a family maintenance needs allowance for qualified family members; (d) a home maintenance allowance; and (e) health care coverage and incurred expenses.

(A) Personal Needs Allowance

A deduction shall be made for a long-term-care applicant's or recipient's personal needs allowance. This amount shall be the Department's current institutional income standard for one person as specified in 106 CMR 506.420.

If the applicant or recipient does not have income totaling the standard, the Department will pay the applicant or recipient an amount up to that standard on a monthly basis.

(B) Deductions for Spousal Maintenance Needs Allowance

A deduction shall be made from the income of an individual who is institutionalized, in accordance with 106 CMR 505.180(A)(2), to provide for the maintenance needs of his or her spouse in the community. These rules apply to the first month of eligibility in an institution and terminate the first full calendar month in which the spouse is no longer institutionalized or no longer has a spouse in the community. This deduction shall be the amount by which the minimum monthly spousal maintenance needs allowance exceeds the community spouse's gross monthly income. To determine the community spouse's available gross income, use the rules for determining countable earned and unearned income types, as defined in 106 CMR 505.210 and 505.220.

(1) Determine the minimum monthly spousal maintenance needs allowance by adding the following amounts:

(a) $1149; and

(b) an excess shelter allowance for the amount of the difference for the community spouse's principal residence when the following expenses exceed 30% of the amount in (a) above.

- Actual expenses for rent, mortgage (including interest and principal), property taxes and insurance, and any required maintenance charge for a condominium or cooperative; and

- The applicable standard deduction under the Food Stamp Program for utility expenses. This amount shall be reduced to the extent that utility expenses are included in the maintenance charges for a condominium or cooperative.

(2) The spousal maintenance needs allowance shall not exceed $1,769 per month, unless subject to a court order or fair hearing decision.

(3) Either spouse may appeal the calculation of income available to the community spouse and the spousal maintenance needs allowance to the Division of Hearings. A spousal maintenance needs allowance that is greater than the amounts described in 106 CMR 506.220(B)(1) or (2) is permitted, after a fair hearing, if either spouse establishes that, due to exceptional circumstances resulting in significant financial duress, the community spouse needs income in excess of what was determined under 106 CMR 506.220(B)(1) or (2).

(4) If the institutionalized spouse is under a court order for the support of the community spouse that is greater than the amount determined in 106 CMR 506.220(B)(1) or (2), that amount must be deducted even if it is greater than the amount in 106 CMR 506.220(B)(2).

(C) Deductions for Family Maintenance Needs Allowances

(1) A deduction shall be allowed from the income of a long-term-care resident to provide for the maintenance needs of the following family members who reside with the community spouse.

(a) Minor child - a child under age 21 of either member of the couple.

(b) Dependent child - a child over age 21 who is claimed as a dependent by either spouse for income tax purposes under the Internal Revenue Code.

(c) Dependent parent - a parent of either spouse who resides with the community spouse and who is claimed as a dependent by either spouse for income tax purposes under the Internal Revenue Code.

(d) Dependent sibling - a brother or sister of either spouse (including a half-brother or half-sister) who resides with the community spouse and who is claimed as a dependent by either spouse for income tax purposes under the Internal Revenue Code.

(2) The family maintenance needs allowance shall be one-third of the amount by which the minimum monthly spousal maintenance needs allowance exceeds the gross monthly income of the family member. The minimum monthly spousal maintenance needs allowance is $1,149.

(D) Deductions for Maintenance of a Former Home

A deduction for maintenance of a home is allowed when a competent medical authority certifies in writing that a single individual, with no eligible dependents in the home, is likely to return home within six months from the month of admission. This income deduction terminates at the end of the sixth month following the month of admission regardless of the prognosis to return home at that time.

The amount to be deducted shall be the federal-poverty-level income standard for one person as defined in 106 CMR 506.430.

(E) Deductions for Health Care Coverage and Other Incurred Expenses

(1) Health Insurance Premiums or Membership Costs

When health insurance premiums or membership costs in a health maintenance organization are deducted from an individual's pay, the individual shall be entitled to a disregard of that amount. This disregard shall be in addition to the $90 work-related expense deduction allowed in 106 CMR 506.120(A)(1) for AFDC-related cases.

In both AFDC-related and SSI-related cases, when payments are made directly to an insurer or to a health maintenance organization, such payments shall reduce the patient paid amount or be considered in meeting the spenddown liability.

(2) Incurred Expenses

Deductions shall be allowed for necessary medical and remedial care expenses that the applicant or recipient has incurred that are not payable by a third party. These expenses include medical or remedial care recognized under state law but not covered by the Medical Assistance Program. These expenses may include, but are not limited to, items listed in 106 CMR 506.540(B)(1)-(4).

These expenses shall be within reasonable limits as established by the Department. Expenses shall be considered to be within reasonable limits provided they are (a) not already covered by the Medicaid per diem rate paid to the long-term-care facility, and (b) certified by a treating physician or other medical provider as being medically necessary.

Such deductions may be applied to reduce the applicant's or recipient's patient paid amount under 106 CMR 506.620. These deductions, as well as all other medical expenses, may be considered in meeting the spenddown liability according to 106 CMR 506.620(B).

506.300: Calculations of Financial Responsibility and Inclusion in the Assistance Unit

(A) Calculation of Financial Responsibility

The calculation of the amount of financial responsibility available from an individual, not included in the assistance unit, to the person for whom he is responsible is provided below.

This calculation does not apply to parents for children or spouse for a spouse who are residing in the same household.

(1) The total countable income of the financially responsible individual is determined in accordance with the income policies of Chapter 505.

(2) From the total countable income, subtract applicable income deductions as determined in accordance with the income deductions policies of this Chapter.

(3) From the result of the above calculation, subtract the applicable MA Income Standard.

(B) Calculation for Inclusion in the Assistance Unit

The calculation for inclusion in the assistance unit of an individual who has the option of being included is described below.

(1) The eligibility of all individuals in the assistance unit is determined including the individual with the option of being included.

(2) If the unit is ineligible, the individual with the optional inclusion may be excluded and the eligibility of the assistance unit recalculated with an MA Income Standard that does not include the optional person.

506.400: MA Income Standards

The MA Income Standards are the standards of need established by the Department and used for the determination of financial eligibility.

Eligibility shall be established for an otherwise eligible individual whose net MA income is equal to or less than the applicable MA Income Standard. If the net MA income is greater than the MA Income Standard, eligibility may be established on the basis of the spenddown provisions except as specified in 106 CMR 506.430.

506.410: Community Cases

The following table provides the MA Income Standards applicable to AFDC-Related and SSI-Related filing units residing in the community.

TABLE OF MA INCOME STANDARDS
COMMUNITY CASES

Number of Persons	Monthly Income Standard
1	$ 522
2	650
3	775
4	891
5	1,016
6	1,141
7	1,266
8	1,383
9	1,508
10	1,633
Each additional person	+ 133

506.420: Long-Term-Care Cases

The MA Income Standard for an AFDC-Related or SSI-Related long-term-care case is $60 per month, with the exception of veterans receiving a pension, pursuant to 38 U.S.C. section 3203. Such veterans shall be allowed to retain their pension payment of $90 per month as their personal needs allowance (PNA) in lieu of the $60 per month PNA.

506.430: Federal-Poverty-Level Income Standards

FEDERAL-POVERTY-LEVEL INCOME STANDARDS
COMMUNITY CASES

Number of Persons	Income Standard
1	$ 568
2	766
3	965
4	1163
5	1361
6	1560
7	1758
8	1956
Each Additional Person	199

(A) The federal-poverty-level income standards are used to determine the financial eligibility of the following person(s):

(1) those aged and disabled persons who meet the basic, categorical, and asset requirements for MA;

(2) qualified Medicare beneficiaries who meet the basic MA requirements and QMB asset requirements described in 106 CMR 507.500; and

(3) children aged six or older but under age 19 who were born after September 30, 1983 and who meet the basic and asset requirements for Medicaid.

(B) Eligibility of children aged one, two, three, four, and five is based on 133 percent of the federal-poverty-level income standards.

(C) Eligibility of the following persons is based on 185 per cent of the federal-poverty-level income standards:

(1) a pregnant woman and her unborn child or children; and

(2) a child or children under age one if that child is not automatically eligible under the provisions of 106 CMR 504.140 and 504.150.

(D) Eligibility for specified low-income Medicare beneficiaries described in 106 CMR 507.510 is based upon 110 percent of the federal-poverty-level income standards.

(E) The spenddown policy described in 106 CMR 506.500 et seq. does not apply when using income standards based upon the federal-poverty-level income standards.

506.440: SSI Payment Standards

MASSACHUSETS SSI PAYMENT STANDARDS

CATEGORY	LIVING ARRANGEMENT			
	A	B	C	E
	FULL COST LIVING EXPENSES	SHARED LIVING EXPENSES	LIVING IN ANOTHER'S HOUSEHOLD	DOMICILIARY CARE (LICENSED R.H.)
Individual				
Aged	$ 550.82	$ 461.26	$ 385.70	$ 715.00
Disabled	536.39	452.40	368.92	715.00
Blind	571.74	571.74	571.74	571.74
Member of a Couple				
Aged	$ 417.36	$ 417.36	$ 318.90	$ 715.00
Disabled	406.53	406.53	308.09	715.00
Blind	571.74	571.74	571.74	571.74

NOTE: The personal care allowance in licensed rest homes is $60.00.
The personal care allowance in long-term-care facilities is $65.00.

506.500: Spenddown Eligibility: Community Cases

Sections 506.500-506.580 apply to otherwise eligible community cases whose net MA income exceeds the MA Income Standard for community cases.

506.510: The Spenddown Period

The spenddown period is a six-month prospective period which starts on the first day of the month of service of the earliest bill used to meet the spenddown amount. This date shall not be earlier than three months prior to the month of application and shall not extend more than six months from the first day of application.

506.520: Calculating the Spenddown Liability

The spenddown liability is the amount of excess income that the applicant or recipient is considered to have available to meet medical expenses during the spenddown period.

The amount by which the Net MA Income exceeds the MA Income Standards is the excess monthly income. The spenddown liability is determined by multiplying the excess monthly income by six.

506.530: Notification of Potential Eligibility

An applicant who has excess monthly income shall be informed that he is ineligible for MA but that eligibility may be established by meeting the spend-down liability.

(A) The applicant shall be notified in writing of the following:

(1) the spend-down liability amount;

(2) the method of calculation;

(3) the procedures for submitting medical bills; and

(4) his responsibility to report all changes in circumstances that may affect eligibility or spend-down amount.

(B) A recipient who has excess monthly income shall be informed that he is ineligible but that eligibility may be re-established by meeting the spend-down liability.

In addition, the recipient shall be notified in writing of the factors set forth in subsection (A)(1)-(4) above.

506.540: Submission of Medical Bills

(A) Criteria

To be eligible on the basis of spend-down, the applicant or recipient shall submit medical bills, paid or unpaid, that in total, equal or exceed the spend-down liability, and that meet the following criteria:

(1) the service shall have been performed no earlier than the first day of the third month prior to the month of application;

(2) the service shall have been provided to a member of the filing unit;

(3) the bill must not be subject to further payment by health insurance coverage or other liable third party coverage; and

(4) the bill shall be for an allowable medical expense as provided in subsection (B).

(B) Allowable Expenses

In addition to all medical services covered by the Medical Assistance Program, examples of other medical expenses which may be applied to the spenddown liability are as follows:

(1) health insurance premiums, credited prospectively for the cost of six months of coverage;

(2) non-prescription drugs;

(3) disposable diapers for an incontinent adult; and

(4) air conditioners, humidifiers, or other health related equipment when prescribed by a physician.

(C) Non-Allowable Expenses

Medical expenses that may not be applied to the spenddown liability include, but are not limited to, the following:

(1) cosmetic surgery;

(2) rest-home care;

(3) weight training equipment;

(4) masseur(euse) services; and

(5) special diets.

506.550: Verification of Medical Expenses

The verification of medical expenses is mandatory and, with the exception of non-prescription drugs, shall be a bill or a written statement from a health care provider that includes all of the following:

(A) the type of service provided;

(B) the name of the person for whom the service was provided;

(C) the amount charged for the service; and

(D) the date of the service.

The verification of non-prescription drugs is mandatory and shall be a receipt from the provider of the drug.

506.560: Interim Changes

The worker shall review an applicant's or recipient's eligibility and spend-down liability upon notification of any interim change occurring prior to meeting the spend-down liability or during the spend-down period.

506.570: Conclusion of the Spend-Down Process

When bills submitted are equal to or greater than the spend-down liability and all other eligibility requirements continue to be met, the applicant shall be notified that he is eligible. The recipient is eligible for payment of all covered medical expenses incurred during that spend-down period, other than those submitted to meet the spend-down liability, as long as all other eligibility requirements continue to be met during the balance of the spend-down period.

506.580: Redetermination of Spend-Down Cases

When an applicant meets the spend-down liability, eligibility continues only to the end of the spend-down period. At the end of the spend-down period, the case shall be closed and redetermined.

A redetermination form shall be sent to the recipient prior to the end of the spend-down period. If the recipient is otherwise eligible, a new spend-down liability shall be determined.

506.600: Spend-Down Eligibility: Long-Term Care Cases

Sections 506.600-506.620 apply to otherwise eligible long-term care cases whose Net MA Income exceeds the MA Income Standards for long-term care cases.

506.610: Calculating the Spend-Down Liability

The spend-down liability for long-term care cases is the amount by which the applicant's or recipient's Net MA Income exceeds the MA Income Standard for long-term care cases. The individual must meet the spend-down liability by incurring expenses for which he is liable.

506.620: Meeting the Spend-Down Liability

(A) If the cost of care in the long-term care facility at the public rate exceeds the excess monthly income (spend-down liability), the spend-down liability is met monthly by payment to the facility and is called the Patient Paid Amount.

(B) If the excess monthly income exceeds the cost of care in the long-term care facility at the public rate, the six-month spend-down provisions for community cases apply.

The spend-down liability shall be the amount by which the Net MA Income exceeds the appropriate MA Income Standard for long-term care cases, multiplied by six.

The applicant must incur allowable expenses equal to the spend-down liability in order to become eligibile for Medical Assistance. The Department will then pay the cost of care for the remainder of the six month spend-down period.

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507.000 Overview of Related Benefits

This chapter describes nonmedical benefits related to the Medical Assistance Program for which recipients may be eligible under certain circumstances.

507.100 Funeral and Burial Expenses

The Department may pay a sum not exceeding $1,100 for the funeral and burial of a recipient provided that the total cost of the funeral and burial does not exceed $1,500 and provided that the recipient and/or his or her financially responsible relative(s) as defined in 106 CMR 505.410(A) and 505.450(A) have insufficient resources to pay for the cost of such funeral and burial. Any resources of the recipient and/or his or her financially responsible relative(s) must be deducted from the maximum allowable cost ($1,500) of the funeral and burial, and the difference, up to $1,100, shall be paid by the Department.

507.110 Verification

Verification of the total cost of the funeral and burial as well as verification of the unpaid portion of such expenses is mandatory.

507.120 Exploration of Alternate Resources

The Department shall explore the availability of all alternate resources prior to authorizing payment for funeral and burial expenses. Social Security death benefits, Veteran's death benefits, prepaid funeral and burial contracts, life insurance, and other funds set aside for funeral and burial expenses as provided in 106 CMR 505.170(0) must be applied to the maximum cost of the funeral and burial.

If RSDI death benefits have been paid to the widow(er) of a deceased wage earner who was living in the same household as the deceased wage earner at the time of death, and the Department has paid for any funeral and burial expenses, the Department shall file a claim for these benefits.

507.130: Reimbursement of Certain Recipients for Out-of-Pocket Expenses

(A) Requirements

The following individuals shall be entitled to reimbursement for certain medical expenses paid by them subject to the provisions of this section:

(1) An individual who:

a. applied for SSI; and

b. was denied SSI benefits by the Social Security Administration; and

c. had his or her initial Social Security Administration decision overturned through the reconsideration process, administrative hearing, Appeals Counsel review, Federal Court review, or reopening under the Social Security Administration rules on administrative finality.

(2) An individual who:

a. applied for AFDC or Medical Assistance; and

b. was denied AFDC or Medical Assistance benefits by the Department; and

c. has had his or her initial incorrect Department decision overturned by a subsequent decision by the Department, the Department's fair hearing process, or the judicial review process.

Reimbursement is limited to bills that are incurred on or after the date of initial Medicaid eligibility, and that are paid between the date of the erroneous application decision and the date on which the recipient is notified of Medicaid eligibility. The bill must have been paid by the recipient or spouse, or the parent of a minor recipient, or a legal guardian.

Reimbursement under this section is for amounts actually paid for care or services that were not but would have been covered under the Medical Assistance Program had eligibility been determined correctly even though those amounts exceed the Medicaid rate. Prior to reimbursing a recipient for care or services that would have required prior approval, the Department may require submission of medical evidence for consideration under the prior approval standards. Reimbursement is available even though the medical care or services were furnished by a provider who does not participate in the Medical Assistance Program.

(B) Verification

Persons seeking reimbursement must provide the Department with:

(1) A bill for medical services that includes:

a. the provider's name;
b. a description of the services provided;
c. the date the service was provided; and

(2) Proof of payment of the bill presented, such as a canceled check or receipt.

Recipients of SSI must also provide documents from the Social Security Administration establishing the date of application and the date of the application denial.

507.200: Home Care for Disabled Children

(A) Home care for disabled children allows a child age 18 or under who is severely disabled to remain at home without consideration of parental income and assets provided the child meets the following criteria.

(1) The child's countable assets and income would be within the MA standards, if he or she were in a medical institution (Sections 505.110 and 506.420); and

(2) The child is a disabled individual as defined in Title XVI of the Social Security Act; and

(3) The state has determined that the child requires a level of care provided in an acute hospital, chronic hospital, or skilled nursing facility as described in Subsections 507.200 (B), (C), and (D); and

(4) It is appropriate to provide such care for the individual outside the institution; and

(5) The estimated amount that would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount that would otherwise be expended for medical assistance for the individual within an appropriate institution.

(B) In an acute hospital the child would require the following care:

(1) direct administration of skilled nursing services, seven days a week, 24 hours daily; and

(2) daily medical management under the direction and supervision of a physician; and

(3) continued use of medical technology and/or invasive techniques to sustain life, such as ventilation, hyperalimentation, or dialysis; and at least one of the following:

a. assistance in some or all activities of daily living (ADL's); or

b. skilled therapeutic service (occupational therapy, physical therapy, or speech/language therapy) seven days a week.

(C) In a chronic hospital the child would require the following care:

(1) direct administration of skilled nursing services seven days a week; and

(2) weekly medical management under the direction and supervision of a physician; and at least one of the following:

a. skilled therapeutic services (physical therapy, occupational therapy, speech/language therapy) five days a week; or

b. assistance in some or all ADL's; or

c. continued use of medical technology and/or invasive techniques to sustain life, such as ventilation, hyperalimentation, or dialysis.

(D) To receive treatment in a skilled nursing facility, the child must be non-ambulatory and with global developmental skills at 12 months or less as indicated by an approved developmental assessment performed by the child's primary care physician or by another professional prescribed by the primary care physician; and require the following care:

(1) supervision and direct skilled nursing services provided by a registered nurse, seven days a week; or

(2) daily management and direct skilled nursing services provided by a registered nurse at least weekly, and substantiated by the delivery of direct daily care by a licensed practical nurse or nurse's aide; and

(3) assistance in all ADL's; and

(4) any combination of skilled therapeutic services (physical therapy, occupational therapy, speech/language therapy) five days a week, but at least one skilled therapeutic service every day; and

(5) treatment by a physician at least once every 30 days.

507.300 Presumptive Eligibility for Pregnant Women

(A) Presumptive Eligibility Requirements

A "qualified provider," as defined in Subsection (C) below, may determine a pregnant woman to be presumptively eligible to receive ambulatory prenatal services from any Medicaid provider if, on the basis of preliminary information, she appears to meet the applicable income standards for pregnant women.

(B) Basis of Presumptive Eligibility Determination

The presumptive eligibility decision will be based on the financial information noted on the Department's application and the verification of pregnancy. If the woman is determined to be presumptively eligible, this completed application shall serve as the Medicaid application.

(C) Definition of Qualified Provider

To be a "qualified provider," a medical provider must meet the following criteria:

(1) Provide ambulatory prenatal services;

(2) Receive funds from or participate in a federal or state program as described in 42 USC 1396r-1. Such providers may include community health centers, hospital outpatient departments, and private obstetrician/gynecologists;

(3) Be designated in writing by the Department that it is a "qualified provider"; and

(4) Fulfill the responsibilities of a "qualified provider" as noted in Subsection (D).

(D) Responsibilities of a "Qualified Provider"

A "qualified provider" must perform the following functions:

(1) Verify pregnancy;

(2) Assist the woman in completing the application;

(3) Make a preliminary income eligibility determination;

(4) Notify the Department within five working days of a presumptive eligibility determination by sending a completed application to the appropriate local welfare office; and

(5) Notify a woman in writing (a) that she is presumptively eligible and (b) of when presumptive eligibility may end (see Subsection 507.300 (G)); or

(6) Notify a woman in writing (a) that she has been determined not to be presumptively eligible, (b) of the reason for the denial of presumptive eligibility, and (c) of the right to file a Medicaid application.

(E) Authorization to Receive Services

Upon receipt of the application, the Department shall provide the woman with an authorization for presumptive eligibility services.

(F) Establishment of Medicaid Eligibility

To establish Medicaid eligibility, a presumptively eligible woman must meet the requirements of Subsection 504.120 (A)(1)(b). The Department shall request information necessary to determine Medicaid eligibility.

(G) Duration of Presumptive Eligibility

A pregnant woman will remain presumptively eligible until the earlier of either of the following:

(1) The day on which a final determination of Medicaid eligibility is made; or

(2) 45 days after the day the presumptive eligibility determination is made if a final determination of Medicaid eligibility is not made.

507.320: Pregnancy-Related Services for Legalized Aliens

(A) Definition

Aliens granted lawful temporary resident status or lawful permanent resident status under sections 245A, 210, or 210A of the INA, who are not described in Subsection 503.200(A) and who meet all other requirements for Medical Assistance, are eligible for the services listed in (B) below.

(B) Services

Services for pregnant women include, but are not limited to, the following:

(1) routine prenatal care;

(2) labor and delivery; and

(3) routine post-partum care.

The 60-day post-partum period begins on the last day of the pregnancy and ends on the last day of the month in which the 60th day occurs.

(6) Notify a woman in writing (a) that she has been determined not to be presumptively eligible, (b) of the reason for the denial of presumptive eligibility, and (c) of the right to file a Medicaid application.

(E) Authorization to Receive Services

Upon receipt of the application, the Department shall provide the woman with an authorization for presumptive eligibility services.

(F) Establishment of Medicaid Eligibility

To establish Medicaid eligibility, a presumptively eligible woman must meet the requirements of 106 CMR 504.120(A)(1)(b). The Department shall request information necessary to determine Medicaid eligibility.

(G) Duration of Presumptive Eligibility

A pregnant woman will remain presumptively eligible until the day on which a final determination of Medicaid eligibility is made in accordance with 106 CMR 502.150.

507.320: Pregnancy-Related Services for Legalized Aliens

(A) Definition

Aliens granted lawful temporary resident status or lawful permanent resident status under sections 245A, 210, or 210A of the INA, who are not described in 106 CMR 503.200(A) and who meet all other requirements for Medical Assistance, are eligible for the services listed in 106 CMR 507.320(B).

(B) Services

Services for pregnant women include, but are not limited to, the following:

(1) routine prenatal care;

(2) labor and delivery; and

(3) routine post-partum care.

The 60-day post-partum period begins on the last day of the pregnancy and ends on the last day of the month in which the 60th day occurs.

507.400: Hospice Care Benefits

(A) Eligibility Requirements

Persons who receive hospice care while living in the community and

(1) who are terminally ill (i.e., a medical prognosis has been made indicating a life expectancy of six months or less); and

(2) who will receive hospice care pursuant to a voluntary election described in (B) below;

will have their financial eligibility determined as if they were in a long-term-care facility, using the community income standard to determine their patient paid amount. See 506.410 and 506.430.

(B) Hospice Care Election

In this section hospice care means that the patient receives medical care of a palliative nature rather than a curative nature. Only the patient or his or her representative can make this decision. This election is for 90 days. The patient may then elect a 90 day extension, and subsequent 30 day extensions.

(C) Verification

Persons receiving hospice care must submit a copy of the election statement that includes the following information:

(1) the effective date of the election;

(2) identification of the elected hospice;

(3) acknowledgment by the recipient or his or her representative that he or she understands the palliative rather than curative nature of the hospice care related to the terminal illness;

(4) acknowledgment by the recipient or his or her representative that he or she understands that access to some Medical Assistance services for the treatment and care of the terminal illness and related conditions will be limited to those provided through the elected hospice as specified in the election statement; and

(5) the signature of the recipient or representative.

(b) deductibles and coinsurance for Medicare Parts A and B.

(2) In addition, an individual who is also eligible for Medicaid is entitled to the full range of Medicaid services available under the Medical Assistance Program.

(C) Eligibility Date

(1) Eligibility for benefits as a qualified Medicare beneficiary shall be effective on the first day of the calendar month following the date of the Department's eligibility determination.

(2) An individual who is determined eligible for Medicaid shall have his or her eligibility date established in accordance with 106 CMR 502.160.

(3) A MassHealth card shall be issued to all eligible QMBs and shall be used by providers to verify the individual's eligibility as a QMB, a Medicaid recipient, or both.

507.510: Specified Low-Income Medicare Beneficiaries (SLMBs)

Under the provisions of Section 4501 of the Omnibus Budget Reconciliation Act of 1990 (OBRA), Medicaid will pay Medicare Part B premiums for certain Medicare beneficiaries who meet all the eligibility requirements of 106 CMR 507.500(A) except income. These individuals are called "specified low-income Medicare beneficiaries" (SLMBs).

(A) Eligibility Requirements

A specified low-income Medicare beneficiary is an individual whose income, as defined in 106 CMR 507.500(A)(5), exceeds 100 percent but does not exceed 110 percent of the federal-poverty-level income standard in 106 CMR 506.430

(B) Benefits

The benefits received by a specified low-income Medicare beneficiary shall be limited to payment of the cost of the monthly Medicare Part B premium.

(C) Eligibility Date

Eligibility for benefits as a SLMB shall be effective beginning with the month of application. Retroactive eligibility may be determined for a period of time not to exceed three calendar months prior to the month of application, but shall not be established earlier than January 1, 1993.

507.500: Qualified Medicare Beneficiaries (QMB)

Under the provisions of Section 301 of the Medicare Catastrophic Coverage Act of 1988, Medicaid will pay the cost-sharing expenses of certain Medicare beneficiaries who meet the requirements of 106 CMR 507.500(A). Such individuals are called "qualified Medicare beneficiaries" (QMBs).

(A) Eligibility Requirements

A qualified Medicare beneficiary is an individual who:

(1) is entitled to hospital benefits under Medicare Part A. This includes individuals entitled to hospital insurance benefits by reason of eligibility for voluntary enrollment in the premium-paying Medicare Part A program;

(2) completes a Medicaid application form;

(3) complies with the general policies and all other activities in the Medicaid application process in accordance with the requirements of 106 CMR 501.000 and 502.000 et seq.;

(4) meets the basic Medicaid eligibility requirements of 106 CMR 503.00 et seq.;

(5) has net income that is equal to or less than the standards in 106 CMR 506.430. (In determining net income, the SSI-related methodologies described in 106 CMR 506.110 and 506.120 shall be applied to the gross countable earned and unearned income as defined in 106 CMR 505.210 and 505.220. Income spenddown, as provided for in 106 CMR 506.500 et seq., is not applicable to QMB eligibility determination.); and

(6) has countable assets (as defined in 106 CMR 505.160) that do not exceed $4,000 for an individual or $6,000 for a couple.

(B) Benefits

(1) Medicaid shall pay the following cost-sharing expenses for qualified Medicare beneficiaries:

(a) monthly premiums for Medicare Part B and, where applicable, for hospital insurance under Medicare Part A (not including the "supplemental premium" (tax surcharge) for catastrophic coverage, which is based on an individual's income tax liability); and

507.515: Right to Apply

The Department shall provide full and complete information about the benefits available to applicants under the Medicaid program and as a specified low-income or qualified Medicare beneficiary. The applicant is entitled to have eligibility determined under all related programs; however, he or she has the right to choose to have eligibility determined only as a specified low-income or qualified Medicare beneficiary. If no such choice is made by the applicant, the Department shall make an eligibility determination for all related programs subject to the time standards and notification requirements of 106 CMR 502.000 et seq.

507.520: Qualified Disabled Working Individuals (QDWI)

Under the provisions of Sections 6012 and 6408(d) of the Omnibus Budget Reconciliation Act (OBRA) of 1989, Medicaid will pay the Medicare Part A premium for certain individuals who would not otherwise be entitled to Part A of Medicare, and who meet all the requirements of 106 CMR 507.520(A). Such individuals are called "Qualified Disabled Working Individuals" (QDWIs).

(A) Eligibility Requirements

A qualified disabled working individual is an individual:

(1) who is entitled to enroll for hospital insurance benefits (Medicare Part A) under Title XVIII, section 1818A of the Social Security Act;

(2) whose net income does not exceed 200% of the federal-poverty-level income standards, in accordance with 106 CMR 506.430, applicable to a family of the size involved. (In determining net income, the SSI-related methodologies described in 106 CMR 506.110 and 506.120 shall be applied to gross countable earned and unearned income as defined in 106 CMR 505.210 and 505.220. Income spenddown, as provided for in 106 CMR 506.500 et seq., is not applicable to QDWI eligibility determinations);

(3) whose countable assets (as defined in 106 CMR 505.160) do not exceed $4,000 for an individual or $6,000 for a couple; and

(4) who is not otherwise eligible for Medicaid.

(B) Benefits

Medicaid shall pay the monthly premiums for hospital insurance under Medicare Part A for qualified disabled working individuals.

(C) Eligibility Date

For persons already enrolled in Medicare Part A, eligibility as a QDWI may be established as early as the third month prior to the month of application provided all the requirements of 106 CMR 507.520(A) are met during this three-month period. For persons not yet enrolled in Part A, eligibility as a QDWI shall not be effective until the individual is enrolled in Medicare Part A. In no event shall the effective date be prior to 7/1/90.

507.550: COBRA Buy-In for Individuals with AIDS and ARC

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), P.L. 99-272, an individual who terminates or reduces his or her hours of employment may elect to continue his or her employer-offered group health insurance at the full cost of the group premium for 18 months after any reduction in or termination of employment. An individual is eligible for an 11-month extension if he or she is determined to be disabled at the time of a "qualifying event" (the date he or she left work).

(A) Eligibility Requirements

The Department shall pay the monthly health insurance premium of an individual (and his or her spouse and dependent children) provided such payment does not exceed the average monthly cost incurred by the Department for the care of an individual with HIV disease and provided the individual meets all of the following conditions.

(1) The individual has elected to continue his or her employer-offered group health insurance within 60 days of the date of terminating or reducing his or her hours of employment or the date the individual was notified of the right to elect continued health insurance coverage, whichever is later;

(2) The individual is a resident of Massachusetts, as defined by 106 CMR 503.100;

(3) The individual meets the citizenship and alienage requirements of 106 CMR 503.200(A);

(4) The individual has a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC);

(5) The individual meets the Social Security Administration's definition of disability; and

(6) The total of the gross annual income and countable assets of the individual and his or her spouse and dependent children does not exceed 300% of the annualized Federal-Poverty-Level Income Standard in 106 CMR 506.430 for a household of that size. Countable assets shall include:

(a) cash (currency, checks or bank drafts in the possession of, or available to, the individual);

(b) bank deposits (including, but not limited to, savings, checking or trust accounts, and term certificates);

(c) current value of securities;

(d) current value of a second car; and

(e) equity value of real estate other than a principal residence.

(B) Verifications

Applicants shall be required to verify the following eligibility factors within 45 days of the date of application.

(1) A diagnosis of AIDS or ARC as verified by:

(a) certification of disability by the Department-designated disability determination unit; or

(b) receipt of social security disability benefits.

(2) United States citizenship or alien status; Massachusetts residence; gross annual income; and the equity value of countable assets. The Department shall accept any evidence submitted by the applicant that reasonably documents these eligibility factors.

(C) Presumptive Eligibility

An individual shall be presumptively eligible for premium payments on the basis of preliminary information if he or she appears to meet the applicable eligibility standards listed in 106 CMR 507.550(A). The presumptive eligibility decision will be based on the information noted on the individual's application and a diagnosis of AIDS or ARC verified in accordance with 106 CMR 507.550(B)(1) or by the written statement of the examining licensed physician.

Premium payments made on behalf of an individual who is presumptively eligible shall be subject to recovery if the individual is subsequently determined to be ineligible.

(D) Termination of Benefits

Eligibility for premium payments shall cease in the calendar month following the month in which any of the conditions listed in 106 CMR 507.550(A) ceases to apply or 18 months, or 29 months if eligible for an extension, after reduction or termination of employment, whichever comes first. Individuals shall receive written notice of the termination of premium payments, the reason for the termination, and their right to appeal such termination in accordance with the provisions of 106 CMR 343.000 et seq.

507.600: Emergency Services for Aliens

(A) Eligibility Requirements

Aliens who are not eligible for Medical Assistance, in accordance with Section 503.200(A)(1) and (2), are eligible for care and services necessary for the treatment of an emergency medical condition if both requirements in (1) and (2), below, are met.

(1) The alien has a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

a. placing the patient's health in serious jeopardy;

b. serious impairment of bodily functions; or

c. serious dysfunction of any bodily organ or part.

(2) The alien must meet all other requirements of the Medical Assistance program, including spenddown provisions in Sections 506.500 - 506.620, with the exception of:

a. furnishing or applying for a social security number; and

b. meeting the citizenship and alienage requirements of Section 503.200.

Aliens lawfully admitted for a temporary purpose such as students, visitors, and diplomats are not eligible for emergency services under this Section.

(B) Period of Eligibility

Medicaid coverage shall be available for emergency services provided to eligible aliens from the first date of treatment for the emergency medical condition through the date on which the condition no longer requires emergency care. Medicaid coverage for labor and delivery shall be available until delivery is complete and mother and child are stabilized.

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508.000: Overview of MassHealth Managed Care

(A) The Department provides a managed care program for primary, specialty, and mental health and substance abuse services. Participation in the program is mandatory for all Medicaid recipients not excluded under 106 CMR 508.120. This program is designed to strengthen continuity of care for recipients, ensure that primary care services are provided in a coordinated manner, and help direct recipients to appropriate specialty care when necessary. Recipients who participate in MassHealth Managed Care will choose either a primary care clinician (PCC) or a health maintenance organization (HMO) as their managed care provider.

(B) MassHealth Managed Care consists of two components: primary care and mental health/substance abuse services.

(1) For recipients who enroll with a primary care clinician, primary care is obtained through the PCC, and mental health/substance abuse services are obtained through the Department's mental health/substance abuse contractor.

(2) For recipients who enroll with a health maintenance organization, both primary care and mental health/substance abuse services are obtained through the HMO.

508.100: Choosing a Primary Managed Care Provider

All Medicaid recipients except those excluded under 106 CMR 508.120 must choose a primary managed care provider. The Department will notify the recipient of the availability of health maintenance organizations (HMOs) (see 106 CMR 501.500(Q)) and primary care clinicians (PCCs) (see 106 CMR 501.500(CC)) in the recipient's geographic area, and of the recipient's obligation to select such a provider within 30 days of notification. The recipient may choose any provider from the Department's list of available HMOs and PCCs in his or her area, if the provider is able to accept new patients.

If the recipient chooses a primary care clinician, the PCC will deliver the recipient's primary care, decide if the recipient needs medical care from other providers, and make referrals for such necessary medical care. All medical services to MassHealth Managed Care recipients except those listed in 106 CMR 450.118 require a referral or authorization from the primary care clinician. Recipients can receive those services listed in 106 CMR 450.118 without a referral from their primary care clinician.

(A) Area. The recipient's area includes those towns served by the recipient's local welfare office, as well as towns contiguous to the towns served by the recipient's local welfare office, taking into consideration access for disabled recipients and prevailing commuting patterns to health care providers in the area.

(B) Assignment to a Primary Care Clinician.

(1) If the recipient does not choose a managed care provider within 30 days of notification by the Department that he or she must choose one, the Department will choose a primary care clinician for the recipient in accordance with the following criteria. The primary care clinician is

(a) in the recipient's area as defined in 106 CMR 508.100(A);
(b) a Medicaid-approved primary care clinician;
(c) physically accessible to the recipient, if the recipient is disabled;
(d) suitable for the recipient's status (for example, the recipient is the appropriate age for a pediatrician);
(e) able to communicate with the recipient directly or through an interpreter, unless there is no medical care available in the recipient's area that meets this requirement; and
(f) located in an area to which the recipient has available transportation.

(2) If the Department determines that no Medicaid-approved primary care clinician meeting the criteria of 106 CMR 508.100(B)(1) is available in the recipient's area, the recipient shall not be required to participate in the PCC program as long as such circumstances prevail. The recipient must participate in the Mental Health/Substance Abuse Program (see 106 CMR 508.110), unless electing to enroll in an HMO.

(3) If, subsequent to a determination by the Department under 106 CMR 508.100(B)(2), the Department determines that a primary care clinician meeting the criteria of 106 CMR 508.100(B)(1) has become available, the Department shall require the recipient to enroll with such a provider, unless the recipient elects to enroll in an HMO.

(C) Notification. The Department will notify the recipient in writing of the name and address of the recipient's primary managed care provider, whether the recipient or the Department made the choice.

(D) Transfer. The recipient may submit a request to the Department for a transfer from one PCC to another PCC under the circumstances indicated below. The recipient may elect to join an available HMO at any time.

(1) Transfer Without Cause. A recipient may transfer from one PCC to any other available PCC who meets the criteria in 106 CMR 508.130 without cause once in a 12-month period that begins on the effective date of enrollment into the PCC program.

(2) Transfer for Good Cause. A recipient may transfer from one PCC to another PCC at any time for good cause. For purposes of this regulation, good cause shall mean that the recipient's current PCC does not meet the criteria in 106 CMR 508.100(B)(1), as determined by the Department.

508.110: Mental Health/Substance Abuse Program

The Mental Health/Substance Abuse Program includes all mental health and substance abuse services for recipients who are subject to the requirements of MassHealth Managed Care and who are not enrolled in an HMO.

(A) Effective July 1, 1992, if a recipient is not excluded from participation in the MassHealth Managed Care program under 106 CMR 508.120, the recipient's provider of mental health and substance abuse services must request and obtain prior service authorization for the services the recipient receives.

(1)(a) In each benefit year, beginning January 1 and ending December 31, recipients may receive any combination of at least six outpatient service visits (the initial encounter benefit) before prior service authorization is required.

(b) The types of services that may be obtained without prior service authorization as described in 106 CMR 508.110(A)(1)(a) are: diagnostic services; individual, group, family, and couple mental health therapy; individual, group, family, and couple substance abuse counseling; case and family consultation; medication visit/review; mental health home visit; and acupuncture detoxification.

(2) Crisis intervention/emergency services do not require prior service authorization.

(3) Prior service authorization is always required for:

(a) all mental health and substance abuse services continuing beyond the period of initial encounter; and

(b) psychiatric day treatment; inpatient hospitalization or freestanding detoxification; methadone dosing; and psychological testing.

(B) Effective October 1, 1992, MassHealth Managed Care recipients may receive nonemergency mental health or substance abuse inpatient hospital services only from those providers that have entered into agreements with the Department's managed care contractor for mental health and substance abuse services or who are otherwise approved to provide services by the Department or its designee. Recipients may continue to receive emergency services from any Medicaid-approved provider, subject to the requirements of 106 CMR 450.125.

(C) Effective January 1, 1993, MassHealth Managed Care recipients may receive nonemergency mental health or substance abuse outpatient and ambulatory services only from those providers that have entered into agreements with the Department's managed care contractor for mental health and substance abuse services or who are otherwise approved to provide services by the Department or its designee. Recipients may continue to receive crisis intervention/emergency services from any Medicaid-approved provider, subject to the requirements of 106 CMR 450.124.

508.120: Excluded Recipients

The following recipients are excluded from the Managed Care program:

(A) a recipient for whom Medicaid is a secondary payer (all health insurance including Medicare);

(B) a recipient who is aged 65 or older;

(C) a Massachusetts Commission for the Blind (MCB) recipient;

(D) a recipient institutionalized in:
(1) a nursing facility;
(2) a chronic disease or rehabilitation hospital;
(3) an intermediate care facility for the mentally retarded (ICF/MR);
(4) a state school for the mentally retarded; or
(5) a state psychiatric hospital;

(E) a recipient who receives retroactive eligibility only;

(F) aliens who are eligible solely for emergency services under 106 CMR 507.600;

(G) a pregnant woman who is eligible only according to the presumptive eligibility requirements at 106 CMR 507.300;

(H) a noninstitutionalized person who will be eligible if his or her incurred bills meet his or her spenddown liability (see 106 CMR 506.500 through 506.580); or

(I) a recipient receiving hospice care.

508.130: Primary Care Clinicians

The list of primary care clinicians that the Department will make available to each recipient may include any one of the following who is a Medicaid-approved PCC practicing within the recipient's geographic area:

(A) a physician in one of the following fields of medicine:
(1) internal medicine;
(2) family or general practice;
(3) pediatrics;
(4) obstetrics;
(5) gynecology; or
(6) obstetrics/gynecology;

(B) an independent nurse practitioner;

(C) a licensed community health center with a practicing physician who meets the requirements of 106 CMR 508.130(A);

(D) an acute hospital outpatient department with a practicing physician who meets the requirements of 106 CMR 508.130(A); or

(E) a group practice with a practicing physician who meets the requirements of 106 CMR 508.130(A).

508.140: Excluded Services

All services are subject to referral by the primary care clinician, unless explicitly excluded by 106 CMR 450.118.

508.150: Right to a Fair Hearing

All recipients subject to the Managed Care program are entitled to a fair hearing under 106 CMR 343.000 et seq. to appeal the Department's

(A) determination that the recipient is subject to the MassHealth Managed Care program under 106 CMR 508.000 through 508.120;

(B) assignment of a primary care clinician under 106 CMR 508.100(B);

(C) denial of a transfer from one provider to another provider under 106 CMR 508.100(D); or

(D) denial of prior service authorization under 106 CMR 508.110.

(106 CMR 508.160 through 508.490 Reserved)

508.500: Copayments

All Medicaid recipients except those excluded by 106 CMR 508.510 are required to make a copayment to the provider of those medical services as described in 106 CMR 508.520.

508.510: Excluded Recipients

The following recipients are excluded from the copayment requirement:

(A) recipients who have not reached their 19th birthday;

(B) recipients who are pregnant, including a postpartum period that extends through the last day of the second calendar month following the month in which pregnancy ends (for example, if the woman gave birth May 15, she is exempt from the copayment requirement until August 1);

(C) recipients who are inpatients in hospitals, nursing facilities, chronic disease or rehabilitation hospitals and intermediate care facilities for the mentally retarded; and

(D) recipients receiving hospice care.

508.520: Services Subject to Copayment

(A) Drugs

All Medicaid recipients except those excluded in 106 CMR 508.510 shall pay $.50 for each prescription for all drugs except those under section 508.530(A) reimbursable under the Medical Assistance Program including the original prescription and all refills; and

(B) Emergency Room Services

All Medicaid recipients except those excluded in 106 CMR 508.510 shall pay the provider $3.00 for services other than those described in 106 CMR 507.600 received in a hospital emergency room.

508.530: Services Excluded from Copayment

The following services are excluded from the copayment requirement:

(A) family planning services and supplies such as oral contraceptives; contraceptive devices (such as condoms and diaphragms); contraceptive jellies, creams, foams and suppositories.

(B) services provided by a health maintenance organization (HMO) to its enrollees.

(C) emergency services provided in other than hospital settings.

(D) all other services not included in Section 508.520.

508.540: Emergency Aid to the Elderly, Disabled, and Children Program (EAEDC)

There is no copayment requirement for medical services provided by the EAEDC program.

508.550: Recipients Unable to Pay

Providers cannot refuse services to a recipient who is unable to pay at the time the service is rendered. However, the recipient is liable to the provider for the copayment amount.

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